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September 13, 2017

The Departments of Labor, Health and Human Services,
and the Treasury (the Departments)

Re: Solicitation of Comments on Draft Model Form

Submitted via email to e-ohpsca-mhpaea-disclosure@dol.gov

To the Departments:

The Blue Cross Blue Shield Association (BCBSA) – a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide healthcare coverage for one-in-three Americans – appreciates the opportunity to respond to the solicitation of comments on a draft model form that participants, enrollees, or their authorized representatives may voluntarily use to request information from their health plan or issuer regarding non-quantitative treatment limitations (NQTL) that may affect their mental health and substance use disorder (MH/SUD) benefits, or to obtain documentation after an adverse benefit determination involving MH/SUD benefits to support an appeal (June 16, 2017, Affordable Care Act Implementation Frequently Asked Questions, Part 38).

The solicitation is in furtherance of two questions that were previously raised in Affordable Care Act Implementation FAQs Part 34:

- a) Whether issuance of model forms that could be used by participants and their representatives to request information with respect to various NQTLs would be helpful and, if so, what content the model forms should include.
- b) Do different types of NQTLs require different model forms?

As indicated in our response to the previous solicitation, a voluntary model form could be helpful when consumers seek information from plans and issuers about NQTLs, though different forms for different types of NQTLs may result in a proliferation of additional disclosures, leading to confusion and higher administrative costs.

We commend the Departments for proposing that the form could, *but is not required*, to be used. It is critical that the form be voluntary because plans must maintain the flexibility to accept requests for information with respect to NQTLs in various formats, and individuals must have flexibility in submitting such requests.

The current, voluntary draft model form is a welcome first step towards reducing burden on individuals, families, health care providers, group health plans, health insurance issuers, and other stakeholders. However, the form would benefit from revisions to simplify further the process of requesting relevant disclosures for consumers, patients, and their authorized representatives. We recommend the Departments revise the forms to:

- Use laymens language wherever possible to explain parity between MH/SUD benefits and medical and surgical benefits – in neutral terms that do not inadvertently convey bias against medical management policies that affect coverage determinations (e.g., a plan may require trying an alternative treatment for reasons other than the treatment is simply “lower in cost,” which sounds like the plan is cutting corners) – and to clarify complexities and ambiguities in the requirements for NQTLs. This should include a plain language review by the Departments’ Communications experts, and consumer pilot testing.
- Give more structure to general information requests to help consumers get more precise answers to questions about treatment limits.
- Eliminate the request for claim/denial information when the claim *was* denied (i.e., an adverse benefit determination) or restricted (e.g., a prior authorization requirement). **Only use the form to obtain general information, or information about claims that “may be” denied and restricted, which is also more general than information about specific denials/restrictions.** Because of other rules and procedures for disclosing information and initiating reviews and appeals, combining requests for general information with requests for information about specific adverse benefit determinations will confuse consumers.

If the Departments still wish to include requests about claims that were denied or restricted, then the form should:

- Include language to ensure consumers understand that the model form is a request for information only and not a request for an appeal or reconsideration from an adverse determination, so that both consumers and plans and issuers understand exactly what is being requested and what response is to be provided.
- Distinguish requests for claim/denial information when the claim was denied or restricted – and the plan has already provided the reason – and when the claim is subject to potential denial or restriction.

- For claims subject to potential denial/restriction, include only those reasons for denials or restrictions that are typically used to make benefit determinations.

We provide details on these and related recommendations in the comments below. In addition, we urge the Departments to consider two broader issues:

- First, the model form should be designed as a tool for consumers, and not intended as an instrument for helping State reviews of compliance with NQTL standards. By its voluntary nature, the form is inherently ill-suited to ensuring uniformity since use of the form may vary widely. Moreover, if as we recommend the form is revised to use plain language, and to avoid complex and legalistic terminology, then it will not necessarily yield the form or type of information that is helpful to state regulators. Assistance to States should be provided through different means.
- Second, how and what plans disclose is inextricably linked with the guidance for NQTLs, which is complex, fraught with many ambiguities, and sparse for some NQTLs (such as provider reimbursement). Therefore, the Departments could simplify or otherwise improve the processes for requesting disclosures by providing an enforcement safe harbor for disclosures that meet good faith requirements. If designed not to be a floor but to promote innovation through flexibility, a safe harbor would give plans and issuers incentive to explore innovative ways of improving disclosures.

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COMMENTS ON THE FORM TO REQUEST DOCUMENTATION FROM AN EMPLOYER-SPONSORED HEALTH PLAN OR AN INSURER CONCERNING TREATMENT LIMITATIONS

Background

Issue:

This introductory section to the model form advises consumers that it is a tool to request information regarding limitations that may affect the consumer's MH/SUD benefits. It explains that parity generally means that coverage limits applied to MH/SUD benefits can't be more restrictive than the coverage limits applied to medical and surgical benefits; that is, coverage limits cannot be applied to MH/SUD benefits unless those limits are comparable to limits applied to medical and surgical benefits. The section notes that parity protections apply to financial limits and treatment limits – and in describing treatment limits, the text mentions both quantitative limitations such as limits on the number of visits and non-quantitative treatment limitation (NQTLs) such as prior authorization.

Recommendation:

The introduction is not consistent with the Departments' explanation in the solicitation that the form is for requesting information regarding NQTLs, not about treatment limitations generally. Further, though "limitations" is the term used in law, in colloquial usage limitation has a negative connotation that creates an adversarial tone and possible bias in reading. Therefore, BCBSA recommends:

- Targeting the tool on NQTLs, though without using the "NQTL" jargon. The introduction should explain that the form is a tool to request information about medical management (such as being required to get prior authorization), formulary design, or similar practices or general plan design that limit the scope or duration of benefits for treating benefits for a mental health condition or substance use disorder.
- Clarifying the meaning of comparable in the context of parity. Consistent with the regulations, the introduction should explain that the process for developing and applying medical management, formulary design, and so on, for MH/SUD benefits must be comparable to and applied no more stringently than the process for developing and applying medical management, etc., to medical/surgical benefits.
- Clarifying that parity is determined on a classification by classification basis: inpatient in-network, inpatient out-of-network, outpatient in-network (which can be sub-divided into office visits and all other outpatient services), outpatient out-of-network (same sub-division), emergency care, prescription drugs.
- Clarifying that parity does not mean equal results: parity is not necessarily violated if NQTLs for MH/SUD and medical/surgical are not exactly the same, and do not yield the same rate of denials or restrictions.
- Testing separate model forms for benefits to treat a mental health condition and benefits to treat a substance use disorder.

Rationale:

As the Mental Health and Substance Use Disorder Parity Task Force noted in its final report, stakeholders representing all constituencies called for further attention to NQTLs. Any model form, therefore, should be explicitly targeted at meeting the disclosure requirements for NQTLs. Moreover, as the Task Force further noted, parity in NQTLs can be difficult to assess because NQTLs are often not listed in plan documents and because comparisons of coverage restrictions and care management strategies between MH/SUD and medical/surgical benefits are complex. Using laymen's terms wherever possible, and clarifying that parity is about processes, not about outcomes, will help consumers engage in

more constructive dialogue with plans and issuers. The NQTL parity requirements are complex enough that the form should go further to explicate the meaning of comparable (as discussed further in recommendations below).

Clarifying that parity is determined on a classification by classification basis will help in honing a consumer's general request for information, as discussed below.

While parity applies in the same way to mental health conditions as to substance use disorders, the unique differences in symptoms between mental health illness and drug or alcohol addiction, and the prevalence of co-occurring conditions for SUDs, makes parity in NQTLs for SUDs perhaps of a different complexity than parity in NQTLs for mental health conditions alone. Testing for the effects of these differences may yield model forms that are better tailored to the unique needs of different subpopulations.

General Information Request

Issue:

This section allows consumers to request information on plan limitations related to MH/SUD generally or to limitations related to coverage for a specific condition or disorder. The type or content of information is not specified: presumably the types of information at the end of the form (#1-4) relate to the "Claim/Denial Information Request," since the box for Claim/Denial simply indicates the consumer was notified (the box for the general request indicates the consumer is requesting information).

Recommendation:

The general information request is too broad and vague to help consumers ask for information in a way that enables plans/issuers to provide a meaningful response. The form should use neutral language understandable to a layman and guide the consumer towards asking the "right" question for his or her circumstances through prepopulated boxes. Therefore, BCBSA recommends:

- Changing the box to "I am requesting information on the plan's medical management or general plan design that may affect the scope or duration of benefits, such as (select one or more):"
 - Prior authorization
 - Utilization review
 - "Fail first" or step therapy
 - Reimbursement rates [These are the four most common forms for NQTLs focused on by commenters to the Mental Health Parity Task Force.]
 - Other _____

- Eliminating “MH/SUD benefits generally,” and allowing instead for the consumer to select categories and levels of care corresponding to the classification schema for the condition or disorder in question. For example, the request for information would be about a specific condition or disorder that relates to:
 - Care received from a hospital in the plan's network.
 - Care received from a residential treatment center in the plan's network.
 - Care received during a visit to a physician in the plan's network.
 - Care received from a partial hospitalization program that is part of the plan's network.
 - Care received from an intensive outpatient treatment program that is part of the plan's network.
 - Care received for any other outpatient services in the plan's network.
 - [Repeat for out-of-network care.]
 - Care received in an emergency room.
 - Prescription drug(s) [Specify the drugs(s)]
- Clarifying that the plan will provide generally applicable information explaining the process it uses for developing and applying the checked off practice(s) to MH/SUD and medical/surgical benefits in each of the checked off classifications/levels of care.

Rationale:

Too wide open a question will result in disparate, wide open responses that won't necessarily educate the consumer about the plan's approach to achieving parity between MH/SUD and medical/surgical benefits. The recommended approach structures the request so that it is tailored to the NQTL(s), by type of care and level of service that will be meaningful to consumers. (Separate forms for MH and SUD could enable greater explanation around different levels of care, and make it easier for plans to present a comparison.)

Clarifying that plans will provide generally applicable information is important for setting reasonable expectations: if one objective of the form is to encourage plans and issuers to improve the quality of informational disclosures for both individuals and groups, the Departments need to set reasonable expectations about what may be provided in response to a request for general information, such as by noting that plans and issuers are not required to create ad hoc disclosures in response to a request for general information, but plans may voluntarily create and provide generally applicable informational disclosures that provide general information related to compliance with mental health parity.

Claim/Denial Information Request

Issue:

This section is for consumers who were notified that a claim for coverage of a mental health condition or substance use disorder was, or may be, denied or restricted for the following reason(s). The form does not clarify the circumstances under which a claim “may be” denied. The consumer then checks off all the reasons for the notification: some are typical reasons for a denied claim (e.g., not medically necessary); some relate to services that are subject to medical managements; and two – my plan does not have any reasonably accessible in-network providers, and I am not sure [about] the methods my plan uses to calculate payment for out-of-network services – would not be offered in a notification of a claim denial or restriction.

Recommendation:

Whether the claim was or has the potential to be denied/restricted, the more information the consumer can provide, the better able plans will be to provide information. We oppose using the form for claims that *were* denied or restricted, but if the Departments keeps the request for information about claims that were denied/restricted it should distinguish those claims from claims that “may be” (or, better yet, “have the potential to be”) denied/restricted. For example:

- I [enter identification number, date of birth] was notified on [enter date] that a claim for coverage [enter identifying information such as date of service, diagnosis or procedure code] **was denied or restricted** [enter reason supplied by the plan in the explanation of benefits, or in another communication from the plan]. (Alternatively, the member could provide the notice of adverse determination.)

- I [enter identification number, date of birth] was advised on [enter date and method of notification, e.g., letter, phone call] that a claim for coverage [enter mental health condition or substance use disorder that is a covered benefit, and information about the type of treatment or drug and level of service] **may be subject to potential denial or restriction** for the following reasons:
 - The claim for the treatment (service or drug) may not be medically necessary.
 - The treatment (service or drug) may be experimental or investigational.
 - The plan requires authorization before it will cover the treatment (service or drug).
 - The plan may require me to try an alternative treatment (service or drug) ~~that is lower in cost~~ before authorizing the treatment that my doctor recommends.

- The plan may not authorize any more treatments because I failed to complete a prior course of treatment.
- Other reason: _____

The *Instructions* should be clarified to avoid confusing consumers: “This information can help you appeal a claim denial, but you must initiate the plan’s general review and appeals process (mental health parity does not create a separate right of appeal).” To further drive home that this form is not designed to initiate an appeal, the reference to contacting EBSA should be removed from the Instructions and placed at the end of the form.

In addition, the instructions should make the consumer or the authorized representative aware that because of privacy concerns the plan may require an authorization form or other procedures to protect privacy.

Finally, because of differences in disclosure requirements between group and individual policies, the Departments should consider different versions of the model form for group and individual policies (or clearly identify and distinguish the differing disclosure requirements).

Rationale:

Whether the claim has been adjudicated, or the member has only called the plan with a question about a potential claim, the plan needs to be sure that it is offering the right information to the right person: a blanket request for information about a denied or restricted claim is too vague.

Distinguishing between claims that were denied/restricted and claims that may be denied/restricted is important because if the claim was denied or restricted, the plan has already provided the reason: asking the member to check off reasons under these circumstances could be confusing to the member and the plan.

For claims that may be denied, the reasons need to be modified to indicate the generally conditional status (except for treatments that definitely require prior authorization). Also, the reference to “requiring me to try a treatment that is lower in cost” carries an unnecessary negative connotation: for example, the alternative treatment may generally be safer, and only if not effective would it make sense to risk the side effects of the treatment the doctor recommends; or the alternative treatment is indeed lower in cost, but it is identical in effectiveness to the treatment the doctor recommends, as when the doctor recommends a brand name drug in lieu of an equally effective generic drug.

We recommend eliminating as a reason “My plan covers my MH/SUD treatment but does not have any reasonably accessible in-network provider” because plans do not advise members that their claims may be subject to potential denial or restriction for that reason. If a member asks about a potential claim for coverage, and the plan does not have the appropriate in-network provider, the plan will likely advise the member about its procedures to get treatment from an out-of-network provider.

We recommend eliminating the reason related to the methods the plan uses to pay for out-of-network services because plans do not advise members that their claims for an out-of-network service may be denied or restricted for such a reason.

If the real issue is that the member feels that the plan’s network lacks an adequate number of behavioral health providers, or does not pay them adequately, then perhaps the form should include a separate section that faces those issues directly, rather than in the context of a claim that may be denied. (Though we would prefer further guidance from the Departments on how to apply parity analysis to reimbursement or network adequacy before giving consumers a model form requesting such information.)

Issue:

The form goes on to explain that coverage limits (presumably those which led to notification the claim was or may be denied) cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits, and requests that the plan:

1. Provide the specific plan language regarding the limitation and identify *all* [emphasis added] of the medical/surgical and mental health and substance use disorder 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 mental health and substance use disorder benefits than to medical and surgical benefits.

Recommendation:

The form should elucidate the concept of comparable by hewing more closely to the rule and providing illustrative examples in laymen’s terms. For instance, the form should clarify that limits for MH/SUD must

be comparable to limits applied to medical and surgical benefits *in the same classification*, and offer illustrative examples, such as the following which is based on example 8 (78 FR 68273) in the final rule:

- The plan requires prior authorization for certain inpatient services beyond 30 days. To decide which services require prior authorization, the plan looks at the medical literature, professional standards, and studies and clinical trials that test the comparative effectiveness of different services. The plan documents this evidence and the way it uses this evidence to decide which inpatient services require prior authorization. Thus, the ways in which the plan determines which MH/SUD benefits require prior authorization for inpatient services and which medical/surgical benefits require prior authorization for inpatient services are comparable.

Item 1 should be narrowed from identify *all* [emphasis added] of the medical/surgical and MU/SUD benefits to identify those that best illustrate that limits are applied comparably. In the context of an appeal (which always carries the potential to lead to litigation), *all* the information is appropriate (so long as it is related to the condition being treated – it is not likely that a member suffers from a condition that is treated by all MH/SUD benefits) but in a model form intended first and foremost for consumers it will encourage open-ended requests that lead to detailed disclosure responses, which would undercut the purpose of a model form that is meant to help, but is not a substitute for, appealing a claim denial.

Items 2 and 3 refer to how plans develop processes for NQTLs, and item 4 refers to how plans apply these processes to NQTLs. However, the language is overly complex and jargon-laden – consumers who have difficulty understanding basic plan design concepts such as deductibles and investigational are unlikely to understand the meaning of “evidentiary standards.” It is also unduly legalistic: the term “provide any evidence” sounds like an audit inquiry, not a question from a consumer, and it strikes an unnecessarily legalistic, adversarial tone which is not conducive to constructive exchanges to help consumers.

Instead, the Departments should develop guidance for plans and issuers clearly explaining what is meant by “factors used in the development of the limitations, evidentiary standards used to evaluate the factors,” and “the methods and analysis used,” and use these explanations to then develop and pilot test language for consumers.

Rationale:

The aim of the model form should be to simplify the process of requesting relevant disclosures for consumers, patients, and their authorized representatives. Using statutory and regulatory language to populate the form will do more to complicate than to simplify this disclosure process. The goal should be to explain in plain English how the processes for developing and applying the factors, standards, methods, and analyses with respect to the mental health or substance use disorder benefit are comparable to and applied no more stringently than those applied to medical or surgical benefits. As

noted by the Mental Health and Substance Use Disorder Parity Task Force, it is important that consumers receive information in understandable and usable ways, without overly burdening plans and issuers. When both consumers and plans/issuers have a common understanding of the terms used in regulatory language, the quality of information disclosure will improve all around.

* * *

Thank you for considering our comments. We look forward to working with the Departments on improving the disclosure request process, for consumers, patients, and their authorized representatives, and for other stakeholders. If you have questions, please contact Joel Slackman, Executive Director, Legislative and Regulatory Policy, at 202.626.8614 or joel.slackman@bcbsa.com,

Sincerely,



Kris Haltmeyer
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