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Director, Office of Health Plan Standards & Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20710

Submitted via email to: e-ohpsca-MHPAEA-SCT-2020@dol.gov

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

Dear Ms. Rivers,

Thank you for the opportunity to review and provide the Department of Labor (the Department) with our comments on the Proposed Updates to the 2020 MHPAEA Self-Compliance Tool. As always, UnitedHealth Group (UHG) welcomes the opportunity for constructive discussion and collaboration as part of this comment process.

UHG is dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of over 300,000 people serves the health care needs, including the mental health and substance use disorder needs, of more than 140 million people worldwide, funding and arranging health care on behalf of individuals, employers, and the government. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers through administration of self-funded and commercial insurance arrangements across all 50 states, including individual and small group exchange plans, and we are also one of the largest Medicaid health plans, supporting underserved communities in 26 States and the District of Columbia.

General Comments:

Overall, we appreciate the updates to the Tool that incorporate and provide additional clarifications that serve to advance the understanding of the Mental Health Parity and Addiction Equity Act (MHPAEA) and MHPAEA compliance for all stakeholders. We note that we have not commented upon each and every update highlighted in the document but have reserved our specific comments and recommendations for those updates we feel may lead to confusion or where there could be additional clarity in the update for maximum benefit to all stakeholders.

We appreciate the thoughtful language used by the Department in setting forth the updates, new notes and examples. We believe these thoughtful language choices have worked to reinforce and address

some key issues with MHPAEA analysis and compliance. For example, on the top of page 28 the Department includes an additional example of methods and analyses to substantiate factors for which the plan is assessing comparability and used the term "summaries of research" rather than just "research" thereby reinforcing that the goal is to provide a level of information supporting comparability and not a level of information requiring a plan to provide each and every piece of research a plan uses. We do believe that one major issue to date with MHPAEA compliance is insistence on a complete comparison of every piece of data or information that goes to a level of granular precision in analysis that serves to undermine the use of the standard of "comparability" which is purposefully contemplated as flexible and not exacting. The Department's language choices and careful drafting of these updates are appreciated, and we'd encourage the Department to be even more explicit and place more emphasis on these points where they arise in the Tool.

We also appreciate the inclusion of additional examples and notes meant to illuminate compliant, as opposed to non-compliant, approaches to the application of MHAPEA by plans such as that in the new Illustration 6 on page 37-38 of the Tool. One recommendation we would offer in this regard is to use a pair of aligned examples that illustrate the same nonquantitative treatment limitation (NQTL) with changes in the fact pattern in the two examples that lead to different conclusions – one compliant and one non-compliant. We believe this approach may be helpful to illustrate how fact-specific and variable the analysis of a given plan and given NQTL can be because a change in the basic fact pattern of an example can result in different results in terms of the ultimate conclusion of compliance or non-compliance.

Specific Comments & Revision Recommendations: Note: For ease of reference we have included the section and page references for each item we are commenting upon in this section.

Page 4, "About This Tool"

The first paragraph of this update regarding the Tool's examples would be a perfect place to re-iterate explicitly a couple general points regarding the assessment and analysis of MHPAEA compliance such as: (1) The inclusion of an illustrative example of non-compliance of any limit (whether quantitative or nonquantitative treatment limit) or financial requirement does not per se mean such a limit is always impermissible or non-compliant and (2) the examples are very fact-pattern specific and the change in any of the facts may result in a different conclusion as to compliance or non-compliance with MHPAEA.

Page 6, "Definitions" Note

We believe the language of this note conceptually, as reflected in the first two sentences of the note, is accurate and correct. The concern we have is with the remainder of the language. Our concern is that the language uses an unclear example that conflates an NQTL and the parity of that NQTL (involving determination of whether the service is "experimental") with the more fundamental point of how the plan categorizes benefits as "medical/surgical" or "mental health/substance use disorder" benefits. We believe the use of a more straightforward example is called for in order to avoid confusion and more clearly illustrate the principle – which we agree with – of the first two sentences of the note.

Page 18-19, "Warning Sign"

We strongly recommend this Warning Sign be removed. The application of the specialist co-pay or cost share to mental health and substance use disorder (MH/SUD) services is frequently compliant based on

the defined "substantially all" and "pre-dominance" tests set forth in the rules and we do not believe this Warning Sign is necessary or prudent. Rather than clarifying the current state of plan financial requirements and their compliance with MHPAEA, the inclusion of this Warning Sign will lead to misunderstanding by some stakeholders, including state regulators, that a plan may not permissibly apply the specialist co-pay to MH/SUD benefits.

The Warning Sign also states a fact pattern that reflects the practical application of the required testing under the rules that actually must occur if the tests are properly followed under the rules – namely that a plan can have multiple different levels of copayment (e.g. primary care and specialist) for medical/surgical benefits in a classification but only one level of copayment for MH/SUD services (i.e. the predominant level of the copay from medical/surgical benefits in that classification). By definition, under the rules only one level of copayment can be predominant and therefore must apply to all MH/SUD services in the classification. In addition, the language and example of this Warning Sign conflicts with the existing material in the Compliance Tips on page 19 that speak to specialist co-payments and will likely generate more confusion rather than the clarity the Department intended.

Page 22, "Note" (First)

We support the inclusion of this Note as a helpful illustration of a comparable process for determining reimbursement rates of in-network providers. We would recommend the Note go further in being explicit and explain that while, as the note indicates, a plan must ensure that variance in rates applied by the plan to account for factors such as the nature of the service etc. must be done comparably and no more stringently for MH/SUD benefits than for medical/surgical benefits, variances in the rates which result from factors and actions outside the control of the plan, such as provider negotiation tactics or regulatory requirements, are not relevant to a parity analysis. These factors and actions do not constitute treatment limitations or financial requirements as defined by MHPAEA and are therefore outside the scope of the rules and a parity analysis.

One possible suggestion for language to be included is to add a sentence to the end of the current language that states: "However, note that any variance in reimbursement rates that result from factors such as regulatory requirements or provider actions, such as contract negotiation, do not constitute limitations imposed by the plan and are therefore excluded from consideration in a proper parity analysis of the plan's limitations and processes for reimbursement."

Page 22, "Note" (Second)

We strongly support the inclusion of this Note as an illustration of the principle, too often misunderstood by stakeholders in discussion of parity, that disparate outcomes are not a parity violation. The Note states that while a plan must take comparable measures that are applied no more stringently to address network adequacy through admission standards and other incentives, there may ultimately be disparate numbers of MH/SUD and medical/surgical providers in its network. We believe that this point needs to be even more strongly articulated as we continue to encounter numerous stakeholders arguing that these differences in outcomes are prima facie evidence of a parity violation by arguing that these differences evidence, per se, a more stringent application of the NQTL.

We recommend the updated guidance clearly address this issue by inserting the following statement at the end of the current language in this Note: "Overall, the assessment of NQTLs must focus on the "comparability" and "applied no more stringently" requirements of MHPAEA with respect to the NQTL

itself and not the results of the NQTL. The presence of disparate numbers of providers in a plan's network, differences in reimbursement rates, differences in denial rates for medical management processes etc. do not by themselves establish meaningful evidence of the non-compliance of an NQTL – either in writing or in operation."

Page 23, "Warning Signs"

This section of Warning Signs, with respect to provider reimbursement, is another example of the Department's careful drafting and use of language that supports key parity compliance analysis concepts which we support. Specifically, Warning Sign #1 discusses the comparison of rates in terms such as "generally" and "at or around" which we believe reflect the inherent and intended unexacting nature and flexibility of the NQTL standard of "comparable." Our recommendation would be to again make this point more explicit by inserting after the first sentence in this paragraph the following: "There is no requirement for exact matching of rates under a parity analysis just a general comparability." We believe this additional statement is also a good segue into the following statement regarding the tool for comparing plan reimbursement rates to a Medicare rate benchmark.

The proffered tool in Appendix II referenced in the Warning Sign however is incomplete and lacks utility as currently drafted and we'd suggest removing this tool, and the reference language to it in this section, until the tool can be more fully developed with a detailed explanation, instructions and examples. For more comments on this tool please see below under "Appendix II".

With respect to the second Warning Sign in this section which discusses evaluation and management (E/M) codes and reimbursement, we would suggest adopting revised and additional language for clarity of this item to make the point again that the parity law and rules do not require psychiatrists be paid the exact same rate as medical/surgical physicians for these codes (and we'd note that not all medical/surgical physicians using these codes are paid the same rate). Rather, the standard is that in the aggregate, or to use the Department's language in the Warning Sign, "on average," the rates paid to psychiatrists must be comparable, or substantially similar to, those paid to medical/surgical physicians on average. We offer the following recommended revision, by adding the following sentence after the existing language: "Note however that the rates for the E/M codes for MH/SUD physicians do not have to be exactly the same as the rates for the medical/surgical physicians but must be generally comparable."

Page 25, "Note"

We strongly support and appreciate the inclusion of this note. The language clarifies that plans have discretion and flexibility in identifying and defining the factors and sources of the factors they use to assess and apply NQTLs. We believe this is a point in need of continuing clarification and reinforcement. There have been stakeholders – including various enforcement authorities – who have attempted to assert that plans may not exercise discretion in designing NQTLs and in assessing factors used in analyzing the parity of those NQTLs, or that a plan must use only factors deemed appropriate by that regulator. These requirements are not supported under MHPAEA and we believe this note and the provided example are a very necessary update to the tool.

Page 28, "Warning Sign 1."

We would like to recommend a modification to this Warning Sign for clarity and to avoid potential misinterpretation of the context of this example. One recent issue we have encountered with state regulators reviewing prior authorization NQTLs in the pharmacy classification is that some state regulators are taking the position that in order to apply a prior authorization to a single class of mental health/substance use disorder drug benefits (such as those used to treat opioid use disorder as in this Warning Sign) that the plan must apply prior authorization to all classes of medical/surgical drug benefits. We believe this Warning Sign example could potentially reinforce this incorrect application of parity.

Accordingly, we would recommend modifying the Warning Sign to read as follows:

1. *Prior authorization for medication for opioid use disorder:* A plan or issuer imposes prior authorization for a class of medications for the condition of opioid use disorder but does not require prior authorization for any classes of medications for a single medical/surgical condition (e.g. statins for cardiac disease).

Page 29, "Warning Sign 3."

This example on the "different medical review requirements" is not consistent with the principle that parity compliance is established by using similar factors, evidentiary standards, and thresholds to identify and trigger the application of a NQTL, is likely to be misinterpreted, and uses an unrealistic example.

The use of a different number of visits based on condition specific guidelines consistent with generally accepted standards of care before triggering medical necessity review is almost universally going to be true such that this Warning Sign will lead to a significant amount of inquiry and investigation of NQTLs that are actually compliant.

In other words, there are almost no instances where a plan, applying generally accepted standards of care, would have the same number of visits to trigger review of all medical/surgical conditions and all mental health/substance use disorder conditions that would be equal numbers (e.g. 8 visits). For example, a plan could use a factor that establishes the same threshold for triggering medical necessity review (e.g. the number of visits that exceed the 95th percentile for average length of stay/episode of care) whereby the actual number of visits for MH/SUD may well be different in number but the threshold is comparable.

Experience suggests that this Warning Sign will be interpreted to mean that the number of visits must be the same which is generally not going to be true based on generally accepted standards of care as noted above. Accordingly, we would advise that this example Warning Sign be withdrawn or revised to a different example such as where a plan uses a more stringent threshold for mental health/substance use disorder services (e.g. the number of visits exceeds the 75th percentile for average length of stay/episode of care) when the same plan uses a higher threshold for medical/surgical services (e.g. a 95th percentile threshold).

Page 33, "Note"

We strongly object to the inclusion of the example provided in this note which references to on-going litigation (*Wit v. United Behavioral Health*) that is not settled law (the case is still not final and is subject

to appeal). We believe the note and the point of the paragraph – that MHPAEA disclosure requirements are not dispositive of compliance with other state and federal laws that may apply to a plan – is amply demonstrated by the example of the SPD requirements under ERISA as set forth in the second paragraph of the updated language. Given this, we urge the Department to eliminate the example in this first paragraph referring to the *Wit* case and to just use the updated language in the second paragraph.

Page 35, Reference to National Association of Insurance Commissioners Data Collection Tool

We appreciate and support the inclusion of this language. However, the link included to the Data Collection Tool is currently pointing to a "Page Not Found" and should be updated to link to the current version of the tool.

Page 35, Bullet "d"

The inclusion of a sample of covered and denied claims for MH/SUD and medical/surgical benefits needs to have a more clear direction or explanation given with regard to the utility of reviewing such a sample as a possible indicator of more stringent application of a plan limitation. Looking at the raw numbers or rates of claims denials, for example, are not clear indicators of more stringent application of a plan limitation. A disparate outcome, such as differing denial rates for claims, does not indicate a more stringent application of a plan limitation. Many factors can go into a denial such as lack of information from the source to complete the authorization. This implies a provider practice problem not a more stringent application of a plan limitation. A claims sample, to the extent reviewed as a part of a prudent compliance plan practice regarding parity compliance, needs to be reviewed for consistency with the plan as written to assess whether, in operation, there is a parity issue. We believe this point of explanation and clarification should be included in the discussion of this item as a component of a compliance plan.

Page 39, "Appendix II"

As noted above, we are concerned about the inclusion of the Appendix II as currently constituted without any explanation, instructions or examples of its use or utility.

Conceptually we agree that using a tool that allows for an analysis of reimbursement rates of a plan against the benchmark of the Medicare fee schedule rates in order to obtain a "quick and dirty" sense of whether a plan's reimbursement rate methodology is comparable and applied no more stringently can be helpful. However, it needs to be explained that the tool is not a substitute for a proper NQTL analysis but merely a means for looking at the outcome of a plan's reimbursement rate methodology against an external reference point (e.g. the Medicare fee schedule) as a potential indicator of comparability or non-comparability.

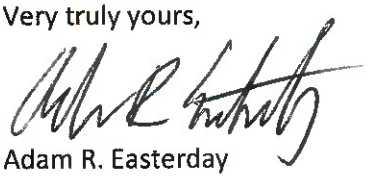
In addition, Appendix II is incomplete and flawed in that it neither explains the concept nor the purpose of this tool. Additionally, it does not provide instructions for its use or any explanation as to why it includes only the provider types listed or only the certain service codes included in the current draft of the tool, among other factors. Absent these elements of explanation and instruction the Appendix will almost certainly generate questions and confusion as well as being improperly used and applied.

We strongly urge the Department to withdraw Appendix II and work with stakeholders to develop a more completely developed tool that includes appropriate explanations, instructions, formatting and examples to ensure clear guidance to stakeholders.

We appreciate the opportunity to review and provide comment on the Department's "Proposed Updates to 2020 MHPAEA Self-Compliance Tool" and would be happy to discuss any of our comments in greater detail or answer any questions the Department may have. Please feel free to contact me directly at adam.easterday@optum.com with any questions or to discuss these comments further.

Thank you for your time and consideration in this matter.

Very truly yours,



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