



July 24, 2020

Filed electronically via email to [e-ohpsca-MHPAEA-SCT-2020@dol.gov](mailto:e-ohpsca-MHPAEA-SCT-2020@dol.gov)

Ms. Amber Rivers  
U.S. Department of Labor  
Employee Benefits Security Administration  
Office of Health Plan Standards and Compliance Assistance  
200 Constitution Avenue, N.W.  
Washington, DC 20210  
Attn: 2020 MHPAEA Self-Compliance Tool

**RE: Comments on Proposed Updates to 2020 MHPAEA Self-Compliance Tool**

Dear Ms. Rivers,

We write on behalf of the American Benefits Council (“the Council”) to provide comments in connection with the Proposed Updates to the 2020 Mental Health Parity and Addiction Equity Act (MHPAEA) Self-Compliance Tool, issued on June 19, 2020, by the U.S. Department of Labor (DOL).

The Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

Council members strongly believe in the value of mental health and substance use disorder (“MH/SUD”) benefits for employees. Although employers have long recognized the importance of offering coverage for MH/SUD benefits, addressing employees’ mental health needs has never been more important than it is now, during the twin health and economic crises. Now, as ever, employers are making efforts to ensure that employees have access to essential mental health services and quality mental health care providers.

As key stakeholders directly impacted by mental health parity requirements, we are committed to working with the DOL in developing reasonable guidance for the provision of MH/SUD benefits provided by group health plans. This letter relates to the DOL's solicitation of feedback on the proposed updates to the 2020 MHPAEA Self-Compliance Tool that group health plans and issuers can – but are not required to – use to help determine compliance with MHPAEA and its implementing regulations.

The Council appreciates the DOL's continued work to provide guidance on MHPAEA's requirements, and the Council commends the DOL for proposing the self-compliance tool updates and giving stakeholders an opportunity to comment. Due to the complexity of MHPAEA, we encourage the DOL to continue to provide stakeholders an opportunity to comment on MHPAEA guidance in the future, including future updates to the MHPAEA self-compliance tool.

In the 2020 proposed update, the DOL notes that the changes generally fall into four main categories:

1. *Integration of Recent Guidance:* The DOL incorporates in the 2020 proposed update guidance from Frequently Asked Questions (FAQs) part 39 on the implementation of MHPAEA, which were finalized in 2019.
2. *Revising Compliance Examples:* The 2020 proposed update revises examples of non-compliance in the 2018 version of the tool to add an explanation of how plans and issuers could correct violations, and also includes appendices with additional examples of compliance.
3. *Best Practices for Establishing an Internal Compliance Plan:* Although a compliance plan is not required by MHPAEA, the 2020 proposed update includes characteristics of a successful internal compliance plan that may assist group health plans in promoting the prevention, detection, and resolution of potential MHPAEA violations, and can help plans and issuers improve compliance with the law. The updated tool also includes examples of the types of records that a plan should be prepared to provide in the event of a DOL investigation.
4. *Warning Signs:* In the 2020 proposed update, the DOL has incorporated additional examples of treatment limitations encountered in recent federal and state enforcement efforts that may be warning signs of a potential violation.

## PURPOSE OF SELF-COMPLIANCE TOOL

While the self-compliance tool can be helpful, it is important to clarify that use of the tool is not imposed on plans or issuers as a requirement. Additionally, it is important that the DOL only use the tool to *clarify* existing guidance, and not impose new requirements through updates to the self-compliance tool.

We request that the DOL clarify in the “About This Tool” section of the self-compliance tool that use of the tool is voluntary for group health plans and health insurance issuers. There is also concern that the DOL is suggesting that, by providing certain information in the tool, there is only one acceptable way for a plan or issuer to demonstrate compliance with MHPAEA, including for certain nonquantitative treatment limitations (NQTLs). However, notwithstanding that the tool provides some helpful examples and information, it is our understanding that it would be permissible for a plan or issuer to use a different process for an NQTL analysis than what is presented in an example or in the appendices, consistent with the requirements under MHPAEA. As such, the Council requests that the DOL clarify that the examples in the self-compliance tool are just that - examples - and explicitly state that there are other ways that a plan or issuer may be able to show compliance with a specific NQTL.

In the 2020 update to the self-compliance tool, the DOL incorporates additional examples of treatment limitations encountered in recent Federal and State enforcement efforts that may be warning signs of a potential violation. We request that the DOL add language to the tool explaining the purpose of the “Warning Signs.” Specifically, DOL could clarify in the “About This Tool” section that “Warning Signs” are not determinative of a MHPAEA violation but may serve as red flags to possible impermissible treatment limitations, warranting further review of the plan’s or issuer’s documentation.

More generally, in future guidance or updates to the tool on which there is an opportunity for notice and comment, the Council requests the DOL issue more fully developed examples of best practices, including examples of permissible medical management practices. We think this would enhance the transparency of the enforcement process and reduce the risk of confusion among plans and issuers.

## UPDATES TO SELF-COMPLIANCE TOOL

The DOL states that “[t]his tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law.” Thus, it is reasonable to believe that plans, issuers, and other stakeholders (e.g., state regulators) may rely on information provided in this tool to comply with MHPAEA.

We request that the DOL identify updates to the self-compliance tool, specifically where information is published for the first time and not in other existing examples in the regulations or FAQs. For example, language added to existing examples, new examples and updates to the appendices added as part of this proposed update should have a notation that this information/language was added on the date the Final 2020 MHPAEA Self-Compliance Tool was posted or as part of the publication of the Final 2020 MHPAEA Self-Compliance Tool. This is important for all stakeholders, including other regulators, and potential reliance on the self-compliance tool as DOL guidance. Importantly, the DOL's inclusion of a notation of when certain information was provided as part of an update to the self-compliance tool makes clear when this information was made available to the regulated community.

## **MEDICATION ASSISTED TREATMENT**

As one of the updates to the 2020 self-compliance tool, the DOL provides an example relating to coverage for Medication Assisted Treatment, specifically noting that “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 [*sic*] permissible in the absence of a comparable process to determine limitations for the treatment of medical/surgical conditions.”

While the Council agrees that MHPAEA requires that a comparable process be used for determining limitations on the treatment of MH/SUD conditions as for medical and surgical conditions, this example is focused on the results and could be read to be making a conclusory statement that requiring behavioral or psychosocial therapies or services concurrent with medication for opioid use disorder would not be permissible. In this example, the DOL should note that, as part of the process for determining limitations, plans and issuers may include clinical considerations and appropriate standards of care, and that disparate results between medical and surgical and MH/SUD benefits is not determinative of a violation. The Council requests that the DOL add some additional clarifying language to this example explaining the various factors that may be taken into consideration when determining what limitations will be placed on MH/SUD and medical and surgical benefits and that disparate results are not determinative of a violation.

As another update to the 2020 self-compliance tool, the DOL adds an illustration noting that a plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. We appreciate the DOL emphasizing the role of a P&T Committee and noting in the illustration that it is the *process* that must

be comparable for determining coverage for both MH/SUD and medical and surgical conditions. However, the Council requests that the DOL clarify that “nationally recognized clinical standards” to determine coverage for prescription drugs to treat both MH/SUD and medical/surgical benefits do not have to be the same, and in some instances, it may be appropriate for the nationally recognized clinical standards to be different for medical/surgical and MH/SUD conditions. This will ensure that clinicians have the flexibility to rely on the appropriate medical standards for determining coverage for prescription drugs.

## **PROVIDER REIMBURSEMENT**

In the 2020 updates to the self-compliance tool, the DOL provides additional examples for the provider reimbursement NQTL, noting that “[f]or 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.” This example may be interpreted to mean that MHPAEA’s NQTL rules require plans and issuers to use the same exact reimbursement methodology for both MH/SUD and medical/surgical providers, and this is not the case. MHPAEA does *not* require plans and issuers to use the same exact methodology or process in determining reimbursement rates for providers (or any NQTL). Rather, to comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a *comparable* process in determining reimbursement rates for providers for both medical/surgical and MH/SUD benefits. Moreover, such an interpretation may be problematic for plans and issuers that use a behavioral health organization (BHO) for administration of its behavioral health benefit, because it is common for the BHO to set reimbursement rates for providers by using a comparable, although not identical, process. This example appears to suggest that such an approach may not be permissible, which is not the case. The Council requests that the DOL revise this example so that it reflects that plans and issuers need not use the exact same reimbursement methodology for MH/SUD and medical/surgical providers.

In addition, the 2020 updates to the self-compliance tool include as a provider reimbursement NQTL warning sign “inequitable reimbursement rates established via a comparison to Medicare.” The 2020 updates also include a new appendix, intended to help plans and issuers compare plan reimbursement rates to Medicare. While we understand the general purpose of the tool in Appendix II, and appreciate that it may be one method of setting and/or analyzing reimbursement rates for providers for MHPAEA compliance, we are concerned that this tool is focused on “results,” and is not process-oriented. Whether a plan or issuer complies with MHPAEA, specifically the provider reimbursement NQTL, is determined based on the plan or issuer’s process for setting reimbursement rates, including all of the factors and evidentiary standards that

are considered as part of that process. MHPAEA does not require reimbursement rates to be the same, or even comparable – again, it is the process that is required to be comparable.

#### **REFERENCE TO *WIT V. UNITED BEHAVIORAL HEALTH***

In the discussion about MHPAEA’s disclosure requirements, the DOL advises plans and issuers to be sure that the plan or issuer, in addition to the MHPAEA disclosure requirements, is disclosing all information relevant to medical/surgical and MH/SUD benefits as required pursuant to other applicable provisions of law. In the 2020 updates to the self-compliance tool, the DOL adds as an example, “if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan may be complying with MHPAEA, but failing to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with the plan documents” and instructs the reader to refer to *Wit v. United Behavioral Health*, No. C-14-2346 JCS (N.D. Cal. Feb. 28, 2019).

The plaintiffs in *Wit* were participants in ERISA-covered group health plans administered or insured by United Behavioral Health (UBH). The plaintiffs alleged that UBH breached its fiduciary duties of loyalty, care and to follow the plan document under ERISA, by developing and using internal medical necessity guidelines for making coverage determinations that were more restrictive than generally accepted standards of care, which was the standard in the plaintiffs’ plans. The court also found that UBH’s reliance on the internal guidelines was arbitrary and capricious. In March 2019, a federal magistrate judge in the Northern District of California held that UBH was a plan fiduciary with respect to the plaintiffs’ plans by virtue of its designation as administrator of MH/SUD benefits under their plans, and UBH breached its fiduciary duty under an abuse of discretion standard by adopting internal guidelines that are unreasonable and more restrictive than generally accepted standards of care.

The Council requests that the DOL refrain from citing to the *Wit* case for two reasons. First, the case is still ongoing, and it is possible that the decision by the district court may not be upheld. Second, the case does not involve MHPAEA and seems misplaced (or at the least, premature) to include in this 2020 update.

#### **COMPLIANCE PLAN AND DOCUMENTS TO SUPPORT COMPLIANCE**

The Council thanks the DOL for providing information about successful internal compliance plans and specifically for noting that an internal compliance plan is *not*

required by plans and issuers under MHPAEA. In the section “Responding promptly to detected offenses and developing corrective action,” the DOL notes that “[i]f a plan or issuer discovers a violation of MHPAEA, it should take steps to correct these violations promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries.” The Council requests the DOL clarify that, in practice, retroactive relief may not be feasible, and in such instances, notice to participants and beneficiaries would not be appropriate. In such circumstances, prospective changes by a plan or issuer would be the proper corrective action. This clarification is important to recognize that corrective action may take different forms, and will be based on all of the facts and circumstances of the violation.

Also, the Council is appreciative of the DOL sharing information about the documents that may be requested as part of a MHPAEA investigation. This is helpful for plans and issuers to maintain the necessary documentation for MHPAEA compliance.

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As noted above, employers are committed to providing essential and quality MH/SUD benefits to their employees and we recognize the vital importance of mental health coverage. Thank you for the opportunity to share our views and for the continued dialogue.

If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

A handwritten signature in black ink that reads "Katy Johnson". The signature is written in a cursive, flowing style.

Katy Johnson  
Senior Counsel, Health Policy