LAW AND REGULATIONS GOVERNING DISCLOSURE OF HEALTH PLAN INFORMATION

PROVISIONS FOR PURPOSES OF MHPAEA COMPLIANCE ANALYSIS

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Purpose

This Background Paper was prepared by the American Psychiatric Association (APA)[1] for the purpose of detailing the provisions governing the disclosure of health plan information related to compliance by health plans with The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its Final Rules (Final Rules).[2] These disclosure provisions include provisions of MHPAEA, as well as provisions of other laws and regulations that enable plan participants, beneficiaries, and their authorized representatives to obtain plan information related to their medical/surgical and mental health and substance use disorder (MH/SUD) benefits. In addition, this Background Paper identifies issues with some of the provisions related to the disclosure of essential plan information that requires further clarification and provides recommendations to improve transparency and access to medically necessary health benefits.

Overview: Essential Things to Understand

> ***Even with these existing disclosure requirements under existing law, the Departments remain focused on transparency and whether individuals have the necessary information to compare NQTLs of medical/surgical benefits and mental health or substance use disorder benefits under the plan to effectively ensure compliance with MHPAEA.[3]***

This Background Paper centers around the Departments' focus set forth above to ensure transparency so that individuals have the necessary information to make certain that their benefits are in compliance with MHPAEA (the "Departments' Stated Focus"). Transparency is absolutely essential to ensuring that plan participants and beneficiaries receive the medically necessary health benefits they are entitled to. Proper disclosure of pertinent health plan information is essential to this transparency and this transparency ensures health plan accountability. This is true whether a patient is trying to understand an adverse benefit determination[4] or challenging an

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[1] All comments and questions regarding this paper can be directed to Sam Muszynski at imuszynski@psych.org.

[2] 29 USC 1185a and 29 CFR 2590.712.

[3] 78 FR 68248.

[4] As set forth in 29 CFR 2560.503-1(m), an adverse benefit determination is:

inappropriate nonquantitative treatment limitation imposed by a health plan. Many of these participants and beneficiaries have cognitive and/or functional impairments that may compromise their ability to understand their rights and how to comply with a health plan's required paperwork and hurdles (e.g., financial requirements and treatment limitations, such as utilization management requirements and claims processes and internal appeals, and external review processes) required to access their MH/SUD benefits. Without clear and practical disclosure requirements and compliance with such requirements by health plans and their contractors, this particular patient population may not receive appropriate treatment or may wind up receiving no treatment at all. Lack of clear guidance on disclosure requirements is also highly problematic for the persons, including providers, who act on behalf of patients as their authorized representatives.

MHPAEA has specific disclosure provisions, which can be found in sections of the law and regulations labeled "Availability of Plan Information." However, the bulk of the provisions that afford patients access to plan information (whether prior to the time a claim is filed or after a claim as been denied) are found throughout the laws and regulations governing ERISA and Affordable Care Act (ACA) exchange plans, including the claims procedures and internal appeals and external review processes. Given that there are various laws and regulations that govern the disclosure of information, disclosure is not an easy concept for patients to understand and the requirements are not simple to navigate. This is especially true, if the health plan is less than forthcoming about its obligations and the rights of patients to information about their benefits, benefits denials, and rights to have claims appealed and reviewed by their plans.

When reviewing the provisions of law regarding the disclosure of information, it is essential to understand that the obligation of health plans to disclose information depends primarily on: (1) the different categories of information respecting MHPAEA issues that are subject to disclosure; (2) the different regulatory disclosure

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> … any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

requirements that govern one or more of these information categories and the required content of the disclosure; (3) the fact that each regulatory disclosure requirement specifies different events that trigger the obligation to disclose; and (4) the fact that each requirement stipulates which parties are required to make and which parties are entitled to obtain the disclosure, under its respective provisions. Therefore, it is important for a patient or authorized representative to know what type of information she is looking for, whether the patient is covered by an ERISA or an individual or ACA exchange plan, whether she needs the plan information in lieu of a claim or following a claim denial, and who the appropriate party is that needs to disclose the information.

In addition, it is important to understand that with the exception of disclosures through a Summary Plan Description (SPD) or a Summary of Benefits and Coverage (SBC), the key information categories that are subject to a disclosure request are:

- the specific reason for the denial of benefit coverage;
- the medical necessity criteria related to MH/SUD benefits;
- the medical necessity criteria related to medical/surgical benefits; and
- the instruments (including documents developed by the plan) that evidence that all financial requirements and treatment limitations (i.e., QTLs and NQTLs (including medical necessity criteria)) imposed by the plan, have met the appropriate regulatory tests.

Generally, plan participants in ERISA covered health plans can access a wealth of information regarding their plan's benefits. While MHPAEA enables a potential or current plan participant to obtain a copy of a health plan's medical necessity criteria related to his MH/SUD benefits in lieu of a claim for benefits, part 104 of ERISA enables a plan participant upon request to obtain copies of plan documents and instruments under which a plan is established and operated, which would include a variety of information related to a plan participant's benefits, including any limitations to the benefits, the medical necessity criteria, and any information about the benefits' compliance with the law. This information is available to a plan participant at any time and a request can be made prior to the time a claim is denied. ERISA plan participants are also entitled to information relevant to a claim denial in order to supplement a claim file and appropriately seek an appeal or review of a claim. These rights are found in the appropriate claims procedure and internal claims and appeals and external review processes regulations. See attached Exhibit A.

To establish and operate a health plan under ERISA, it is a given that the plan be compliant with applicable law. Documents that evidence analyses of legal and regulatory requirements and substantiate such compliance are instruments under which the plan is established and operated. It follows that this is the "necessary

information" individuals need to compare NQTLs and to effectively ensure transparency of plan information and compliance with MHPAEA. If these analyses are not subject to disclosure, then the Departments' Stated Focus has no effect.

For individuals, who are covered by individual or health exchange plans, a plan participant's rights to the disclosure of information are more limited. Prior to a claim denial, a plan participant or beneficiary who is covered by a plan that is also covered by MHPAEA can make a request pursuant to MHPAEA for a copy of a plan's medical necessity criteria related to its MH/SUD benefits. In addition, upon a claim denial, plan participants and beneficiaries can obtain information that is relevant to a claim denial and appropriately seek an appeal or review of a claim. These rights are found in the appropriate claims procedure and internal claims and appeals and external review regulations. See Exhibit B.

A participating provider can act on behalf of a plan participant or beneficiary as the authorized representative to assist the plan participant or beneficiary in obtaining plan information. However, under MHPAEA, a participating provider has the right to request a copy of a plan's medical necessity criteria related to the MH/SUD benefit even without having been made a beneficiary's authorized representative.

Summary of MHPAEA and the Final Rules

MHPAEA is landmark legislation that requires group health plans and health insurance issuers to have parity between MH/SUD benefits and medical/surgical benefits with respect to financial requirements and treatment limitations (both quantitative treatment limitations (QTLs) and nonquantitative treatment limitations (NQTLs)).[5] The law and its implementing regulations, the Final Rules,[6] are very detailed and contain specific tests to determine compliance.

MHPAEA and the Final Rules set forth a general parity requirement that prohibits health plans and health insurance issuers from: (a) applying any financial requirement or treatment limitation to MH/SUD benefits in any benefits

[5] Financial requirements are defined in the Final Rules as aspects of the plan design that outline cost sharing between the plan and the enrollee (including copayments, coinsurance, deductibles, and out-of-pocket limits). Treatment limitations, on the other hand, can be quantitative or non-quantitative. Quantitative treatment limitations (QTLs) are defined to include treatment limitations that are expressed numerically, such as calendar year limits on the number of office visits or inpatient days, or lifetime limits on the coverage of benefits. Nonquantitative treatment limitations (NQTLs) are treatment limitations that are not mathematical by definition, but otherwise limit the scope or duration of a benefit. See 29 CFR 2590.712(a). The Final Rules provide for illustrations of NQTLs, which are described in footnote 12.

[6] 29 CFR 2590.712.

classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same benefits classification; and (b) imposing a separate financial requirement or treatment limitation that is applicable only with respect to MH/SUD benefits.[7]

The Final Rules address the application of this general parity requirement to financial requirements and treatment limitations (both QTLs and NQTLs), using specific rules and tests to be applied based on the circumstances related to the financial requirement or treatment limitation in question. As discussed above, a health plan cannot impose separate financial requirements, QTLs, or NQTLs that are applicable only to MH/SUD benefits.[8] Neither MHPAEA nor the Final Rules provide for an exception to this prohibition and there are no permissible justifications for the imposition of a separate financial requirement or treatment limitation.

Where a health plan imposes financial requirements, QTLs, or NQTLs to both MH/SUD and medical/surgical benefits, a health plan must apply the appropriate regulatory tests and determine whether they are in compliance with the law and its rules. For financial requirements and QTLs, the Final Rules provide tests that weigh whether the financial requirements or QTLs applied to MH/SUD benefits are more restrictive than the predominant financial requirement or QTL applied to substantially all medical/surgical benefits.[9]

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[7] See 29 USC 1185a and 29 CFR 2590.712(c). See also the *Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act* that was developed by Milliman, Inc. in conjunction with the Partnership for Workplace Mental Health at http://www.workplacementalhealth.org/Publications-Surveys/Employer-Guide-for-Compliance-with-the-Mental-Health-Parity-and-Addiction-Equity-Act.aspx.

[8] See 29 USC 1185a(a)(3)(A). See also FAQ #2 at http://www.dol.gov/ebsa/faqs/faq-aca7.html.

[9] 29 CFR 2590.712(c)(3). See also 29 CFR 2590.712(c)(2)(i) for the six permissible classifications of benefits (i.e., inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care, and pharmacy).

To determine compliance with the parity tests that apply to financial requirements and QTLs, a health plan must first separate its benefits into the six benefits classifications and determine if the financial requirement or QTL applies only to MH/SUD benefits. If the applicable financial requirement or QTL only applies to MH/SUD benefits, the financial requirement or QTL is a separate treatment limitation and is prohibited by law. 29 CFR 2590.712(c)(3)(ii).

If the financial requirement or QTL applies to both MH/SUD and medical/surgical benefits, the health plan must determine if the financial requirement or QTL applies to "substantially all" of the medical/surgical benefits in a benefits classification. A financial requirement or QTL is considered to apply to substantially all medical/surgical benefits in a benefits

For NQTLs, defined by the Final Rules as treatment limitations that are not mathematical in nature, but that otherwise limit the scope or duration of a benefit,[10] the test to be applied by health plans is different from the tests used to determine the compliance of financial requirements or QTLs.[11] For NQTLs, there is a two-part test that weighs whether the NQTL is (1) comparable to, ***and*** (2) applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits.[12]

The Final Rules provide many illustrations of NQTLs, which include medical necessity criteria and medical management or utilization review standards (e.g., preauthorization requirements, concurrent review, and retrospective review).[13]

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classification if it applies to at least two-thirds of all medical/surgical benefits within that benefits classification. If a type of financial requirement or QTL does not apply to substantially all of the medical/surgical benefits in the benefits classification, that type of financial requirement or QTL cannot be applied to the MH/SUD benefits in that classification. 29 CFR 2590.712(c)(3)(i)(A).

If the type of financial requirement or QTL does apply to substantially all of the medical/surgical benefits in that classification, then the health plan must apply the "predominant" test. This means that the health plan must determine the level of the type of financial requirement or QTL that is the "predominant" level in a classification of benefits. The "predominant" level means that the financial requirement or QTL applies to more than half of the medical/surgical benefits in that benefits classification based on plan costs. If a single level of a type of financial requirement or QTL applies to more than one-half of the medical/surgical benefits subject to the financial requirement or QTL within a benefits classification, it is the predominant level and the health plan cannot apply the financial requirement or QTL to the MH/SUD benefits at a level that is more restrictive. 29 CFR 2590.712(c)(3)(i)(B).

However, if there is no one level that applies to more than half of the medical/surgical benefits subject to the financial requirement or QTL in a benefits classification, the health plan can combine levels until the combination of the levels applies to more than half of the medical/surgical benefits subject to the financial requirement or QTL in the classification and be in compliance with the general parity requirement as long as it does not apply the financial requirement or QTL to MH/SUD benefits at a level that is more restrictive than the least restrictive medical/surgical level within the combination. 29 CFR 2590.712(c)(3)(i)(B)(2).

[10] 29 CFR 2590.712(a).

[11] 78 FR 68245. The Departments used a different test for NQTLs, because NQTLs are not mathematical in nature.

[12] 29 CFR 2590.712(c)(4). The "predominant" and "substantially all" tests that apply to financial requirements and QTLs do not apply to a health plan's NQTLs. The Final Rules require the application of a different test, because NQTLs are not mathematical in nature. See 75 FR 5413 and 78 FR 68245.

[13] 29 CFR 2590.712(c)(4)(ii).

Therefore, the NQTL test of comparability and stringency in application must not only be applied to the medical necessity criteria to determine compliance with the Final Rules, but must also be applied to any and all medical management protocols used in determining whether the benefit is medically necessary. The NQTL test must also be applied to all NQTLs (e.g., criteria for admission to a provider network (including reimbursement rates), network adequacy, etc.) to determine their compliance with the law and the Final Rules.[14]

To ensure compliance with MHPAEA and its regulations, health plans must perform a compliance review of their financial requirements, QTLs, and NQTLs.[15] This analysis does not have to be performed annually, but an analysis must be performed and must be revisited and revised (as necessary) in the event of a change to any requirements or limitations.[16]

Summary of the Disclosure Issue

MHPAEA's requirements provide for transparency and disclosure through the provisions of MHPAEA and the Final Rules that address the "Availability of Plan Information."[17] In addition to certain disclosure requirements included among the "Availability of Plan Information" provisions, the Final Rules also direct readers to other applicable disclosure requirements under ERISA law and regulations,[18] the

[14] Illustrations of NQTLs in the Final Rules include formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; plan methods for determination of usual, customary, and reasonable charges; refusal to pay for higher cost therapies until it can be shown that a lower cost therapy is effective (i.e., fail-first policies or step therapy protocols); exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage. See 29 CFR 2590.712(c)(4)(ii). *In addition, the Preamble to the Final Rules provide that these illustrations are not a comprehensive list of NQTLs and that all NQTLs, whether or not listed in the Final Rules or its Preamble, are subject to the tests provided by MHPAEA and the Final Rules.* Other NQTLs not specifically enumerated in the illustrative list include: (i) in- and out-of-network geographic limitations; (ii) limitations on inpatient services for situations where the participant is a threat to self and others; (iii) exclusions for court-ordered and involuntary holds; (iv) experimental treatment limitations; (v) service coding; (vi) exclusions for services provided by clinical social workers; and (vii) network adequacy. See 78 FR 68246.

[15] See 75 FR 5426. The Departments stated that they "assume[d] that insured plans will rely on the issuers providing coverage to ensure compliance, and that self-insured plans will rely on third-party administrators to ensure compliance." See also 78 FR 68250.

[16] 78 FR 68250.

[17] See 29 USC 1185a(a)(4) and 29 CFR 2590.712(d).

[18] See 29 CFR 2520.104b-1.

claims procedure and internal claims and appeals and external review processes regulations,[19] and the SBC requirements of the ACA.[20]

Furthermore, the Departments have issued specific directives and subregulatory guidance (including Frequently Asked Questions (FAQs) and opinion letters) in order to guide all affected parties in the appropriate disclosure of information to current and potential plan participants, beneficiaries, authorized representatives;, and contracting providers and to clarify the scope of disclosure of plan documents and other information, including who is entitled to receive the information (i.e., the current or potential plan participant, beneficiary, authorized representative, or contracting provider). The Departments' Stated Focus indicates that an individual should be able to effectively obtain the information necessary to perform the appropriate regulatory tests, determine whether plans are in compliance, and seek the compliance of health plans with the law and the Final Rules.[21]

Following the enactment of the ACA, issues regarding disclosure of plan information are important to the Departments since they are not only issues that affect patients with MH/SUDs, but involve the appropriate disclosure of information to all insureds. The ACA created a more transparent marketplace with additional consumer protections, some of which are addressed in this paper, and compliance with these consumer protections is essential to fulfilling the purpose of not only MHPAEA, but the ACA as well. It follows that in order to carry out the intent of both MHPAEA and the ACA, the limitations to the ACA's disclosure provisions that are addressed below (i.e., that participants of exchange plans do not have the same rights to information that ERISA participants have) need to be discussed and eliminated.

The Availability of Plan Information requirements, along with the related guidance issued and other laws, regulations, and guidance regarding plan benefits, provide for the disclosure of information and protections for plan participants and beneficiaries related to MHPAEA compliance, as follows:

[19] See 29 CFR 2560.503-1, 26 CFR 54.9815-2719T(b)(2)(i), 29 CFR 2590.715-2719(b)(2)(i), and 45 CFR 147.136(b)(2)(i) (requires non-grandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1).
[20] In September 2014, the United States Department of Labor's Employee Benefits Security Administration published a Reporting and Disclosure Guide for Employee Benefits Plans that sets forth a brief summary of the disclosure requirements under ERISA. For a copy of this document, see www.dol.gov/ebsa/pdf/rdguide.pdf.
[21] Id.

1) ***MHPAEA and the Claims Procedures and Internal Claims and Appeals and External Review Processes Regulations Entitle Plan Participants, Beneficiaries, and Authorized Representatives to a Reason for the Denial of MH/SUD Benefits.***[22] The plan administrator of a health plan or the health insurance issuer must make available the specific reason for denial of reimbursement or payment of services with respect to MH/SUD benefits to any plan participant or beneficiary in accordance with the regulations regarding claims procedure and internal claims and appeals and external review processes related to adverse benefit determinations.[23] The claims procedure and internal claims and appeals and external review processes regulations also require health plans to provide very specific information about claims, adverse benefit determinations, and appeal information in order for the plan participant or beneficiary to understand a denial and know how to appeal the denial (if necessary).[24]

2) ***MHPAEA Entitles Current or Potential Plan Participants, Beneficiaries, and Contracting Providers to Medical Necessity Criteria Related to MH/SUD Benefits Upon Request.***[25] The plan administrator of a health plan or the health insurance issuer must make available the criteria used for medical necessity determinations made in connection with MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request, regardless of whether there is a claim for benefits or an adverse benefit determination in question. MHPAEA and its regulations do not provide for a current or potential participant, beneficiary, or contracting provider to obtain a copy of the plan's medical necessity criteria related to medical/surgical benefits.

3) ***Other Laws and Regulations Entitle Current or Potential Participants, Beneficiaries, or Authorized Representatives to the Disclosure of Information.***[26] MHPAEA's disclosure requirements, as described above, do not solely determine whether a health plan or health insurance issuer is in compliance with the laws that afford disclosure of plan

[22] 29 CFR 2590.712(d)(2).
[23] See 29 CFR 2560.503-1 and 29 CFR 2590.715-2719.
[24] Id.
[25] 29 CFR 2590.712(d)(1).
[26] 29 CFR 2590.712(d)(3).

information to plan participants and beneficiaries. Other provisions of law and regulations require the disclosure of information to plan participants, beneficiaries, or their authorized representatives. For example, certain provisions of ERISA require the disclosure of plan documents by plan administrators independent of a benefits claim or adverse benefit determination.[27] ERISA also requires that plan administrators disclose SPDs to plan participants, and the ACA requires that health plans disclose SBCs to individuals.[28] There are also claims procedure and internal claims and appeals and external review processes regulations that require the disclosure of relevant information related to both MH/SUD and medical/surgical benefits in order to ensure appropriate review of an adverse benefit determination.[29]

4) ***The Internal Claims and Appeals and External Review Procedures Entitle Plan Participants, Beneficiaries, or Authorized Representatives to Seek External Review of an Adverse Benefit Determination on the Basis of MHPAEA Compliance and Obtain All Needed Information Through Disclosure.***[30] The Internal Claims and Appeals and External Review Processes Interim Final Rules provide that a claimant can seek external review of a claim that involves an adverse benefit determination based on "medical judgment," which includes whether a plan is complying with the NQTL provisions of MHPAEA and the Final Rules.[31] As a result, a claimant or his authorized representative is entitled to all information relevant to the adverse benefit determination in order to ensure an appropriate review or appeal of a claim based on MHPAEA compliance by the external review entity.

[27] See 29 USC Section 1024(b)(4), 1132(c)(1) and 20 CFR 2520.104b-1.
[28] See 26 CFR 54.9815-2715(a)(2)(i) [IRS], 29 CFR 2590.715-2715(a)(2)(i) [EBSA], and 45 CFR 147.200(a)(2)(i) [HHS].
[29] See 29 CFR 2560.503-1, 26 CFR 54.9815-2719T(b)(2)(i), 29 CFR 2590.715-2719(b)(2)(i), and 45 CFR 147.136(b)(2)(i)
[30] 76 FR 37216.
[31] Id.

5) ***MHPAEA Requires Health Plans and Health Insurance Issuers to Ensure that their Plan is in Compliance with MHPAEA When it Uses Contractors to Administer or Manage its MH/SUD Benefits.***[32] While not an Availability of Plan Information requirement, the disclosure of information between the health plan and the contractors it uses to administer or manage its MH/SUD benefits is necessary. The Final Rules provide that the health plan has final responsibility for ensuring compliance with MHPAEA.[33] As a result, health plans must ensure that their contractors, such as managed behavioral health organizations (MBHOs), have sufficient information to ensure that MH/SUD benefits are coordinated with the plan's medical/surgical benefits for purposes of complying with MHPAEA. Therefore, health plans and MBHOs must not only be compliant with the parity tests provided for in the law and the Final Rules, but must also be compliant with all of the disclosure obligations required by MHPAEA and the Final Rules, as well as other disclosure requirements that apply to health plan benefits.

[32] 29 CFR 2590.712(e) and 78 FR 68250.
[33] Id.

Laws and Regulations Requiring Disclosure

A detailed review of the disclosure requirements (along with a discussion of what is to be disclosed pursuant to provisions of law, regulation, and other guidance), issues regarding the ability of plan participants and beneficiaries to obtain necessary plan information, and recommendations for improving access to plan information are set forth below. Also, attached hereto are our recommendations at Exhibit C and summaries of the laws, regulations, and other guidance at Exhibit D.

1) ***MHPAEA and the Claims Procedures and Internal Claims and Appeals and External Review Processes Regulations Entitle Plan Participants, Beneficiaries, and Authorized Representatives to a Reason for the Denial of MH/SUD Benefits.***

a. The Law and the Final Rules.

Both MHPAEA and the Final Rules require that the reason for the denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available by the plan administrator or the health insurance issuer to the participant or beneficiary.[34] The Final Rules further specify that the reason for the denial must be made in a form and manner consistent with the requirements for claims procedures set forth in 29 CFR 2560.503-1.[35]

Like MHPAEA and the Final Rules, 29 CFR 2560.503-1 requires a health plan to provide the plan participant or beneficiary with the specific reason(s) for a denial.[36] 29 CFR 2560.503-1 provides more detail than the Final Rules with respect to the reason for denial in that it states that the reason or reasons must be included in a written or electronic notification of an adverse benefit determination.[37] 29 CFR 2560.503-1 also requires the disclosure of additional information by health plans and provides other protections to plan participants and beneficiaries in its adverse benefit determination requirements.

While the Final Rules only reference 29 CFR 2560.503-1, there are other laws that relate to the disclosure of the reason(s) for a denial and other plan information that must be included in the notification of an adverse benefit determination. Prior to the ACA, 29 CFR 2560.503-1 applied only to ERISA covered group health plans.

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[34] See 29 USC 1185a(a)(4) and 29 CFR 2590.712(d)(2). See also FAQ #8 at FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation: http://www.dol.gov/ebsa/faqs/faq-aca17.html and Question 43 of the Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions at http://www.dol.gov/ebsa/pdf/cagappa.pdf.

[35] 29 CFR 2590.712(d)(2). See also 29 CFR 2560.503-1.

[36] 29 CFR 2560.503-1(g)(1)(i) and (j)(1)(i).

[37] 29 CFR 2560.503-1(g)(1) and (g)(1)(i).

However, after the ACA was enacted, these regulations were extended to all group health plans and individual health insurance coverage through the addition of 29 CFR 2590.715-2719[38]. As a result, almost all health plans must comply with the ERISA claims procedure rules (i.e., 29 CFR 2560.503-1), as well as new rules regarding internal appeals and external review processes found in 29 CFR 2590.715-2719. 29 CFR 2590.715-2719 not only addresses the reason(s) for a denial of a claim, but also provides other standards required of plan administrators and health insurance issuers related to notices of adverse benefit determinations.

Combined, 2560.503-1 and 29 CFR 2590.715-2719 provide the following disclosure requirements:

- The plan must disclose the provisions relied upon in making the denial, all information necessary to perfect the claim, a description of the available internal appeals and external review processes and an explanation of how to initiate an appeal or review, and the availability of potential civil actions under ERISA (if applicable).[39]

- Notices must include information sufficient to identify a claim (including the date of service, provider name, claim amount (if applicable), and availability of the diagnosis and treatment codes).[40]

- The reason for denial must include the denial code and its meaning and a description of the standard used in denying the claim,[41] and the health plan must provide a description of the available internal appeals and external review processes and information necessary to initiate an appeal.[42]

- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement must be made that such internal rule, guideline, protocol, or similar criterion must be provided upon request.[43]

- For denials based on medical necessity, the health plan must provide an explanation of the scientific or clinical judgment used to make the

[38] See 29 CFR 2560.503-1, 26 CFR 54.9815-2719T(b)(2)(i), 29 CFR 2590.715-2719(b)(2)(i), and 45 CFR 147.136(b)(2)(i) (requires non-grandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1).
[39] 29 CFR 2560.503-1(g).
[40] 29 CFR 2590.715-2719(b)(2)(ii)(E)(1).
[41] 29 CFR 2590.715-2719(b)(2)(ii)(E)(3).
[42] 29 CFR 2590.715-2719(b)(2)(ii)(E)(4).
[43] 29 CFR 2560.503-1(g)(1)(v)(A).

decision, applying the terms of the plan to the participant's medical circumstances. [44] Based on this provision, the denial should be specific to the participant or beneficiary and provide the reasons why the prescribed service is not medically necessary for the particular participant or beneficiary.

- The notice provided by the health plan should be provided in a manner calculated to be understood by the claimant.[45]

- The plan must provide the participant with information regarding the availability of any office of health insurance assistance or ombudsman to assist participants with internal claims, appeals, and external review processes and their appropriate contact information.[46]

- In the case of a final internal adverse decision, the description of the standard used to deny the claim must include a *discussion of the decision*.[47]

- Before the plan or issuer can issue a final internal adverse benefit decision based on a new or additional rationale, the claimant must be provided with the new or additional rationale free of charge, as soon as possible, and sufficiently in advance of the date on which the notice of the final adverse benefit determination is required to be provided.[48] This is required in order to give a claimant enough time to adequately respond to the new reasons for the determination.[49]

The Departments have issued model notices to assist health plans and health insurance issuers, which reflect that notices are to be in plain language and written in a manner that is easily understood by patients.[50] There are separate model notices for each of the following types of determinations: 1) an adverse benefit determination; 2) a final adverse benefit determination; and 3) a final external review decision. The models were developed so that the health plan can enter the specific information regarding the claim at issue and direct the claimant to the specific level of appeal or review that is applicable for the stage of the claim.

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[44] 29 CFR 2560.503-1(g)(1)(v)(B).

[45] 29 CFR 2560.503-1(g)(1).

[46] 29 CFR 2590.715-2719(b)(2)(ii)(E)(5).

[47] 29 CFR 2590.715-2719(b)(2)(ii)(E)(3). The regulatory language provides no clarification on what the discussion of the decision is.

[48]29 CFR 2590.715-2719(b)(2)(ii)(C)(2).

[49] Id.

[50] See www.dol.gov/ebsa/IABDModelNotice1.doc, www.dol.gov/ebsa/IABDModelNotice2.doc, and www.dol.gov/ebsa/IABDModelNotice3.doc

b. Reason for a Claim Denial and Contents of an Adverse Benefit Determination Discussed.

While MHPAEA requires plan administrators and health insurance issuers to provide a specific reason for denial, plan administrators and health insurance issuers have a number of other regulations that they must comply with related to providing a specific reason for denial, along with patient specific information related to an adverse benefit determination and the rights to review and/or appeal a claim denial. As a whole, these regulations provide that the specific reason should be in a form that provides the participant or beneficiary with an understanding as to why their particular claim for benefits was denied and how the denial applies to their specific medical condition. In addition, the notice of denial that is provided to the claimant must provide the information necessary to formulate an informed response in the event the participant or beneficiary wishes to seek an appeal or review of their claim. The regulations also provide for the disclosure by the health plan of a great deal of information concerning the claim, the denial by the health plan, assistance with the claim, and review and appeal options. Without the disclosure of the information required by all of the regulations, the plan participant lacks the means to seek an appropriate appeal or review of a claim.

The statutory and regulatory requirements described herein are meant to protect plan participants and beneficiaries. However, many plans fail to address all of the specific requirements provided by the regulations and many plans fail to use the suggested model forms for adverse benefit determinations. Most plans use complicated form letters with detailed attachments that fail to provide a plain language explanation for patients. We have observed a variable degree of specificity used by plan administrators and health insurance issuers in describing the standard that serves as the basis for the denial. For example, some plan administrators simply provide that, "The benefits were denied, because the treatment is not medically necessary." In this case, there is not enough specificity to ensure that the participant or beneficiary has enough information to pursue an informed review of the claim.

In contrast, some plan administrators provide pages of reasons and standards that were used to deny MH/SUD benefits to a participant or beneficiary. When there is too much information and no meaningful explanation or connection between the material provided and the bases for the specific denial, the participant or beneficiary does not have the ability to wade through pages of detail and determine on exactly what basis they should be seeking the review of the claim. Most patients do not have this ability, and patients with MH/SUDs are especially likely to find this task very difficult to accomplish.

In addition, a review of plan correspondence that we have had access to reveals that some plans include a new rationale when issuing a final internal adverse benefit determination without having provided prior notice to the plan participant or beneficiary. This does not comply with the claims procedure and internal claims and appeals and external review regulations. This leaves plan participants and beneficiaries without enough time to expeditiously appeal the decision. This is especially problematic in the case of an urgent claim for benefits.

Our experience is comparable to the experiences of the Attorney General of the State of New York, who recently found that a number of health plans and MBHOs did not comply with the regulations regarding claims denial notices.[51] Many notices do not explain why the claim is denied or provide member-specific details. Our review of claims denials indicates that they tend to be generic and use boilerplate language. It is also our experience that health plans do not closely follow the model notices provided by the Department of Labor, but instead argue that the information contained in notices is also contained *somewhere* in their forms. As a result, claimants are generally confused, lack enough information to understand the denial, and feel ill equipped to seek a review or appeal.

Another issue with claims denials that hinders the ability of claimants to get assistance is that plan participants and beneficiaries often have trouble finding the appropriate e-mail and/or telephone contact information for plan representatives to ask questions and obtain appropriate information for their appeal. Some plans merely provide a general member services number. While many plans set standards of the speed at which a call is answered by a customer service agent, a plan participant or beneficiary then needs to be transferred (often multiple times) to the correct person to address their questions or issues. Again, this is especially problematic in the event of an urgent claim where timeliness is of the essence and the plan participant or beneficiary is awaiting medically necessary care.

c. Recommendations for Reason for Denial.

Given the foregoing, it is essential for plan administrators, health insurance issuers, and claimants (including their authorized representatives) to have additional regulatory or subregulatory guidance that clarifies the additional specificity that a

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[51] See Settlements for Excellus, Emblem, Value Options, and MVP http://www.ag.ny.gov/pdfs/Excellus%20Parity%20AOD%20-%20Executed.pdf; http://www.ag.ny.gov/pdfs/2014-07-03-EmblemParity_MR.pdf; http://www.ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf; and http://www.ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/new/2014-03-19%20MVP%20Parity_MR.pdf. The New York Attorney General also entered into a Settlement with Cigna. This can be found at http://ag.ny.gov/pdfs/Cigna%20AOD%20Executed%201-7-14.pdf.

plan administrator or health insurance issuer must provide in an explanation of an adverse benefit determination so that a claimant or their authorized representative will be able to prepare for an appropriate appeal or review. While there is a great deal of guidance for plans (including the model notices), this is an area where plans fall short, and this shortfall thwarts the ability of claimants to obtain medically necessary services, let alone exercise the due process rights given by the regulations. It is also important to have additional regulatory or subregulatory guidance, informing plans and issuers of the requirements for appropriately and timely notifying claimants using all of the required elements of both 29 CFR 2560.503-1 and 29 CFR 2590.715-2719.

Additional recommendations are as follows:

i. **More guidance on the specificity of the actual elements of the notice**. Given the differences in specificity of reasons for denial provided by plan administrators and health insurance issuers, it would be helpful to have more guidance or examples to show plan administrators and health insurance issuers what an appropriate reason for denial should look like. Guidance should also inform plans that the reason for the denial and the information about the appropriate appeal mechanism must be provided in a member-specific way. Notices should not be form driven or include significant boilerplate language.

ii. **Guidance reminding plans to use Model Notices.** Health plans should be reminded that the Departments have issued Model Notices, which are consumer friendly and guide the patient at the appropriate level of review. These models should be more closely followed by health plans, as many health plans currently employ complicated forms and attachments, which do not provide a plain-language explanation of the claim denial and the participant's options for appeal. For example, we have reviewed notices from one plan that attaches a brochure detailing internal appeal and external review options for patients. The brochure has three sections. The first section directs the patient to review their member card and determine, based on the numbers and information on the card, what type of coverage they have. Once they determine what coverage they have, they are then directed to figure out what their appeal options are and told to read either section 2 of the brochure to learn about internal appeal options or section 3 of the brochure to learn about external review options. This type of brochure is not consumer friendly and may actually frustrate attempts by patients to appeal claims. Furthermore, it is not consistent with the intent of the law and

regulations in that it does not provide a patient with specific information regarding the claim denial and exactly how to appeal the denial in their particular circumstances. Given issues with notices of adverse benefit determination, the Departments should do spot audits to ensure that the information contained in the model notices is not only included in plan notices to patients, but is included in a way that is consumer-friendly and easy to understand.

iii. **"Complies with" should replace "consistent with".** The Final Rules state that the reason for the denial must be made in a form and manner *consistent* with the requirements of the claims review procedures set forth in 29 CFR 2560.503-1. The word "consistent" leaves room for interpretation by the plan administrator or health insurance issuer to provide notice that is similar, but not identical, to the notice requirements of 29 CFR 2560.503-1. The regulators should make clear that the notice requirements of 29 CFR 2560.503-1 prevail in all cases since this specificity protects patients who wish to appeal adverse benefit determinations. In addition, just as important as 29 CFR 2560.503-1 is 29 CFR 2590.715-2719. The regulations related to internal and external review (i.e., 2590.715-2719) require additional specific information for claimants respecting a reason for denial by a health plan and provide much needed consumer protections. It should be clear that 29 CFR 2590.715-2719 prevails in all cases too.

iv. **Reminder to plans and issuers that it is a regulatory requirement to provide timely notice when using a new rationale in final internal adverse benefit determinations.** Plan participants and beneficiaries are finding it difficult to respond and appeal final internal adverse benefit determinations when they do not receive notice of a new rationale being used by plans in denying benefits in a timely manner. This notice is essential to ensuring access, especially in the case of urgent claims for medically necessary benefits, and plans should be informed of its importance and required to comply. A reminder regarding these requirements would be helpful.

v. **Guidance requiring plans and issuers to make e-mail contacts and telephone numbers for plan representatives readily available to plan participants and beneficiaries.** Plans should make specific and dedicated e-mail and telephone contact information available to plan participants and beneficiaries so they can ask questions and obtain file and other information in a timely manner to prepare for reviews and appeals. It is not adequate to merely give a

general member services number, which has numerous recorded messages and prompts to find the correct party.

2) ***MHPAEA Entitles Current or Potential Plan Participants, Beneficiaries, and Contracting Providers to Medical Necessity Criteria Related to MH/SUD Benefits Upon Request.***

a. The Law and the Final Rules.

MHPAEA and the Final Rules require a plan administrator or health insurance issuer to disclose the medical necessity criteria used with respect to its MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request.[52] Specifically, 29 CFR 2590.712 (d)(1) of the Final Rules provides:

> The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.[53]

This provision of the Final Rules permits individuals who are "potential" participants and beneficiaries to access medical necessity criteria related to MH/SUD benefits upon request. That means that not only can a current participant or beneficiary access this criteria, but an individual who might in the future be a participant or beneficiary can access it too. An individual need not wait for a claim to arise or an adverse benefit determination to be made in order to access the criteria.

In addition, this disclosure provision allows a current or "potential" contracting provider to directly access medical necessity criteria related to MH/SUD benefits upon request. The provider does not need to be acting in the capacity as an authorized representative of a patient to make this request and need not wait for

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[52] See 29 USC 1185a(a)(4), 29 CFR 2590.712(d)(1), and FAQ #9 at FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation: http://www.dol.gov/ebsa/faqs/faq-aca5.html. See also, Question 43 of the Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions at http://www.dol.gov/ebsa/pdf/cagappa.pdf, which mirror the law and Final Rules and provides:

> The plan administrator (or the health insurance issuer) must make available the criteria for medical necessity determinations made under a group health plan with respect to mental health/substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) to any current or potential participant, beneficiary, or contracting provider upon request.

[53] 29 CFR 2590.712(d)(1).

there to be an adverse benefit determination to access the criteria applied to MH/SUD benefits. This interpretation is supported by FAQ 9, which reads as follows:

> **Q9: I am an in-network health care provider and one of my patients is having trouble getting benefits paid for a mental health condition or substance use disorder. Am I entitled to receive a copy of the criteria for medical necessity determinations made by the patient's plan or health insurance coverage?**
>
> Yes. MHPAEA and its implementing regulations state that the criteria for medical necessity determinations made under a plan or health insurance coverage with respect to mental health or substance use disorder benefits must be made available by the plan administrator or health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request.[54]

b. Access to Medical Necessity Criteria for Medical/Surgical Benefits Discussed.

While 29 CFR 2590.712(d)(1) of the Final Rules provides access to the medical necessity criteria used in connection with MH/SUD benefits, it does not provide for the disclosure of medical necessity criteria used in connection with the medical/surgical benefits provided by the underlying health plan. This Section also does not specifically mention the disclosure of processes, strategies, evidentiary standards, and other factors used in applying the medical necessity criteria to MH/SUD benefits, nor does it mention the disclosure of NQTLs other than medical necessity criteria.

Notwithstanding the foregoing, as is provided in 29 CFR 2590.712(d)(3) of the Final Rules, there are many other provisions of law and regulation that require the disclosure of information to current and potential participants, beneficiaries, and authorized representatives, including the medical necessity criteria related to medical/surgical benefits and many other plan documents and instruments related to NQTLs and other MHPAEA compliance issues.[55] The Final Rules and other regulatory guidance, which the Final Rules declare applicable, direct affected parties to sections of ERISA, which require the disclosure of plan documents for plans covered under ERISA (regardless of whether or not there is a claim) to plan participants. Also, the claims procedure regulations, which require disclosure of plan information in the event of an adverse benefit determination, provide access to

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[54] See FAQ #9 in FAQs About Affordable Care Act Implementation V and Mental Health Parity Implementation at http://www.dol.gov/ebsa/faqs/faq-aca5.html.
[55] 29 CFR 2590.712(d)(3).

plan information as well. There are also other provisions mentioned in the Preamble to the Final Rules and found within the internal and external review regulations that provide for the disclosure of information. Many of these provisions are discussed below.

There are a number of key issues related to 29 CFR Section 2590.712(d)(1) for current and potential plan participants, beneficiaries, and contracting providers, which must be addressed. One issue is that Section (d)(1) falls short because it fails to provide plan participants and beneficiaries of individual plans, and other plans not covered by ERISA (e.g., governmental and church plans), with access to medical necessity criteria related to medical/surgical benefits prior to the time a claim is denied. It is inconsistent that the disclosure requirements of the ACA make a person wait to experience an adverse benefit determination that is the fruit of a parity violation. For contracting providers and plan participants and beneficiaries of individual plans (both on and off the exchange), it is not possible to analyze a plan's compliance with MHPAEA prior to a claim denial. Also, without the ability to understand their benefits and the compliance of their benefits with MHPAEA and the Final Rules, plan participants and beneficiaries are unable to make appropriate decisions with respect to the selection of health plans. Without upfront disclosure to all interested parties, there is a lack of transparency and, therefore, a corresponding ability of health plans to avoid compliance with the law and rules.

Achieving transparency with respect to NQTLs (like medical necessity criteria) for both MH/SUD and medical/surgical benefits is especially problematic given the difficulty in obtaining plan information. Certain provisions that address transparency can be found in the Proposed Rule regarding the applicability of MHPAEA requirements to Medicaid and the Children's Health Insurance Programs.[56] For example, in the Proposed Rule, the Centers for Medicare and Medicaid Services require states to publicly share evidence of compliance with the regulations. This makes states and the health plans they use accountable and allows monitoring of compliance and implementation. We would note that there are no comparable provisions regarding disclosure to those recently included within the Medicaid Proposed Rule, and would urge the Departments to consider the addition of many of the same requirements to promote transparency and compliance.

Another issue that has arisen is that health plans are not always forthcoming with their medical necessity criteria. It is not uncommon that a health plan refuses to provide the criteria, because they state that the criteria are "proprietary" or "commercially valuable," despite the fact that there is no exception provided by MHPAEA or the Final Rules that would enable a plan to avoid disclosure on this basis. Other plans simply direct the potential or current plan participant,

[56] See the Proposed Rule at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-08135.pdf.

beneficiary, or contracting provider to a website that provides a summary of the criteria. While this provides a general idea of what the criteria are, it does not detail all of criteria used by the health plan and hence, it is not helpful in understanding the criteria and how they are applied to the MH/SUD benefits. These responses by plans are frustrating to potential and current plan participants, beneficiaries, and contracting providers and violate the law and the Final Rules. In addition, "commercially valuable" is not a defined term and a plan could designate almost any plan information as "commercially valuable" and avoid its disclosure obligation.

c. <u>Recommendations for Disclosure of MH/SUD Medical Necessity Criteria.</u>

In addition to the issues above, several points with respect to Section (d)(1) of the Final Rules need to be addressed:

i. Definition of Medical Necessity Criteria and <u>Requirement to Disclose Processes, Strategies, Evidentiary Standards, and Other Factors Used to Apply an NQTL</u>. We request that the sponsoring Departments clarify what is meant by the term "medical necessity criteria." Many of the NQTLs illustrated in the Final Rules are part of a plan's medical necessity criteria. For example, we contend that fail-first protocol is assumed to be part of the plan's medical necessity criteria, as it is a core component of the criteria by which the criteria are applied. Some plans would argue, however, that fail-first protocols are not part of the medical necessity criteria and are not disclosable as such. It is our understanding that this interpretation is not consistent with the intent of the Departments. The Departments did not mean to create loopholes for plans to avoid disclosure of information relevant to plan participants and beneficiaries to determinate whether plans cover MH/SUD treatments.

Many health plans hold the view that since Section (d)(1) of the Final Rules does not mention anything except the medical necessity criteria related to the MH/SUD benefit and does not specifically require the disclosure of anything else, including the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, they do not have to disclose any other information, including the processes, strategies, evidentiary standards or other factors used to apply the medical necessity criteria. While we acknowledge that the sponsoring Departments do not specifically refer to the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, by definition, the processes, strategies, evidentiary standards, and other factors may be embedded within medical necessity criteria and, therefore, should be subject to the disclosure requirement. For example, medical necessity criteria could be applied using a medical management protocol (e.g., prior authorization or concurrent review). This type of

information is essential to a beneficiary or participant in understanding how the protocol is applied to their benefits. As a result, regulatory guidance should be issued confirming that health plans must disclose the processes, strategies, evidentiary standards, and other factors used to apply an NQTL along with the medical necessity criteria related to MH/SUD benefits.

ii. Requirement to Disclose Medical Necessity Criteria Related to the Medical/Surgical Benefits and Other Plan Instruments. Section (d)(1) of the Final Rules does not provide that a potential or current plan participant, beneficiary, or contracting provider can obtain medical necessity criteria related to the medical/surgical benefits. While a number of potential or current plan participants can obtain medical necessity criteria related to medical/surgical criteria under ERISA Part 104, those current or potential plan participants and beneficiaries not covered by an ERISA plan (e.g., individual plans and ACA exchange plans) and contracting providers cannot obtain this criterion absent an adverse benefit determination. As a result of this, while these individuals can review the medical necessity criteria related to MH/SUD benefits, they cannot obtain enough meaningful information to perform a compliance review of their benefits as a whole. We ask the Departments to review this shortfall and seek to afford all plan participants, beneficiaries, and contracting providers with the information necessary to ensure compliance with MHPAEA and the Final Rules. There should be a meaningful way for all individuals to assess plan compliance in lieu of a claims denial.

iii. Requirement to Disclose Information Related to Other NQTLs. While Section (d)(1) affords current and potential participants, beneficiaries, and contracting providers the ability to obtain medical necessity criteria related to MH/SUD benefits, it does not afford them the opportunity to review information related to other NQTLs (e.g., network tier design; formulary design for prescription drugs; standards for provider admission to participate in a network; plan standards for determining usual, customary, and reasonable standards; fail-first policies and step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that would limit the scope or duration of benefits). All NQTLs, by definition, limit the scope and duration of the MH/SUD benefit. Without disclosure of all NQTLs, a current or potential participant, beneficiary, or contracting provider cannot truly understand a plan's MH/SUD benefits. We also ask the Departments to review this shortfall and seek to afford all plan participants, beneficiaries, and contracting providers with the necessary information to ensure compliance with the law and the rules. Transparency is necessary to ensure compliance. Our recommendation is supported by FAQ #C-17. *See footnote 56.*

iv. <u>Clarification on the Disclosure of Medical Necessity Criteria that May be Deemed Proprietary or Commercially Valuable by the Health Plan</u>. Our experience would suggest that a number of health plans state that they cannot disclose medical necessity criteria that they deem proprietary, "commercially valuable," or subject to a vendor agreement. There is no regulatory or other guidance related to MHPAEA that permits plans to avoid disclosure by citing the proprietary, commercially valuable, or contractual nature of their criteria. Guidance to address the ability of health plans to avoid disclosure by asserting that their criteria is proprietary, commercially valuable, or provided through a vendor arrangement is important.

v. <u>Clarification that Health Plans Must Disclose All of the Criteria.</u> Our experience also suggests that a number of health plans refer those requesting medical necessity criteria to a website that provides a summary of the criteria, but not all of the criteria. This falls short of meeting the regulatory requirement. Guidance to clarify that health plans must disclose the all of the medical necessity criteria and how they are applied to the requester's MH/SUD benefits is necessary.

vi. <u>Guidance on Timeline for Disclosure.</u> While MHPAEA requires plan administrators and health insurance issuers to provide medical necessity criteria related to MH/SUD benefits upon request, there is no guidance regarding the time frame in which they must provide the criteria to the requestor. While this may seem technical, it is necessary to discuss and provide for an appropriate time frame. Without such guidance, a plan administrator or health insurance issuer does not have to provide the criteria in a timely manner. Please note that ERISA plan participants are entitled to request these criteria under ERISA Section 104(b) regulations on disclosure of plan documents, which must be provided within 30 days.

vii. <u>Requirement to Provide Responsible Party for Disclosure</u>. If a plan has contracted with a managed behavioral healthcare organization (MBHO) to administer or manage the MH/SUD benefit, the plan should be required to make it clear who the current or potential participant, beneficiary or contracting provider should contact for the appropriate MH/SUD medical necessity criteria. Likewise, if self-funded, the plan should be required to make it clear who is responsible (i.e., the named plan administrator or the entity managing the plan). Furthermore, if the individual is in a plan that is contracting with an MBHO, the plan should be required to make it clear who they should ask for this information. There is considerable confusion about who, in fact, is the responsible party for disclosure.

viii. <u>Arrangements Should be Made to Ensure that Participants Obtain</u>

Criteria. Plans should be required to make appropriate arrangements with MBHOs to access medical necessity criteria related to MH/SUD benefits, so that the criteria can be provided to requesting participants or MBHOs should be required to release the information directly to the participants pursuant to the Final Rules.

ix. Plans Should Provide Appropriate Contact Information. Plans should be required to provide relevant information regarding an appropriate contact person and the e-mail address and telephone numbers for that contact person to ensure that the appropriate disclosure of information to a plan participant or beneficiary can be accomplished.

x. Clarification of Required Documentation for Authorized Representative. There also needs to be clarification of what is acceptable documentation to confirm that someone is acting in an authorized representative capacity, namely legally sufficient forms, as opposed to only the plan's internal form.

3) ***Other Laws and Regulations Entitle Current or Potential Participants, Beneficiaries, or Authorized Representatives to Disclosure of Information.***

The full scope of a plan's disclosure responsibility must be understood and discharged in the context of all applicable laws and regulations that require disclosure of plan information to plan participants, beneficiaries, and authorized representatives. In addition to disclosure of the reason(s) for denial and the disclosure of medical necessity criteria related to MH/SUD benefits, the MHPAEA Final Rules in Section (d)(3) also direct plans, issuers, providers, and individuals to a number of other laws and regulations established under ERISA and/or the ACA, that require the disclosure of information relevant to health plan benefits, including, without limitation, MH/SUD and medical/surgical benefits.[57] The Final Rules specifically state that the disclosure requirements in Sections (d)(1) and (d)(2) do not determine whether the plan administrator or health insurance issuer is in compliance with other laws that afford disclosure of information to plan participants and beneficiaries.[58]

The other controlling laws and regulations providing for disclosure of plan information and documents as directed by the Final Rules to apply to MHPAEA are as follows:

1. Disclosure of Plan Information and Instruments.

Certain laws and regulations entitle participants and beneficiaries to the disclosure of plan information prior to the time a claim is filed or an adverse benefit determination is made.

ERISA.

a. The Law and the Final Rules.

The Final Rules remind readers that ERISA requires the disclosure of plan documents to plan participants, who have a right to request documents at any time before or after an adverse benefit determination. No benefit claim event is necessary to exercise the right to receive plan information. Specifically, the Final Rules provide for disclosure of plan documents as follows:

[57] Id. See also 78 FR 68247.
[58] Id.

> …ERISA section 104 and §2520.104b-1 of this chapter provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.[59]

MHPAEA's Final Rules specifically state that ERISA participants can access instruments under which the plan is established or operated within 30 days of a request for such information. These instruments include the medical necessity criteria related to both MH/SUD and medical/surgical benefits and the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to benefits under the plan, regardless of whether there is a claim or an adverse benefit determination. In addition, although not specifically stated in the Final Rules, this ERISA disclosure right applies to the disclosure of ***all*** instruments under which a plan is established and operated, including documents related to the establishment of financial requirements, QTLs, all NQTLs (not just medical necessity criteria), and any documents or instruments that may be deemed proprietary or commercially valuable.[60]

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[59] Id. See also Section 104(b)(2) of ERISA, which requires a plan administrator to make copies of the plan description, the latest annual report, bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated available for examination by any plan participant or beneficiary, and Section 104(b)(4), which requires plan administrators to furnish these documents to participants and beneficiaries upon request. There is case law, which variously interprets the requirements of whether a document is an "instrument under which a plan is established and operated." See Bartling v. Fruehauf Corp., 29 F.3d 1062 (6th Cir. Ohio 1994), Hughes Salaried Retirees Action Comm. v. Adm'r of the Hughes Non-Bargaining Ret. Plan, 72 F.3d 686 (9th Cir. Cal. 1995), Faircloth v. Lundy Packing Co., 91 F3d 648 (4th Cir. N.C. 1996), and Board of Trustees of the CWA/ITU Negotiated Pension Plan v. Weinstein, 107 F3d 139 (2d Cir. N.Y. 1997). However, there is no case on point that we could find with respect to the disclosure of instruments or documents which evidence compliance with law or regulation related to a health benefit plan. Regardless of the case law, with respect to medical necessity criteria, it is clear that the sponsoring Departments have found that medical necessity criteria is an instrument under which a plan is established and operated and no question exists as to its status.

[60] See FAQ #C-17 at http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html, which provides:

With respect to who can access these instruments, the term "plan participants" includes:

> … any employee or former employee who is or may become eligible to receive the benefit. Employees who are not enrolled (e.g., in a waiting period or who are shopping options for the open season) are considered plan participants.[61]

Therefore, pursuant to ERISA, individuals who are participants or who "may become eligible" to be participants under a health plan covered by ERISA are entitled to obtain instruments under which a plan is established and operated. Accordingly, plan participants may request and receive these instruments before they make a decision as to whether to participate in their employer's health plan.[62] Plan participants can also authorize a third party in writing to request and obtain these instruments on their behalf.[63]

Per the Preamble to the Final Rules, the conclusion that instruments under which a plan is established and operated include medical necessity criteria and the processes, strategies, evidentiary standards, and other factors used to apply an NQTL is supported and further explained by the Pension and

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C-17: Is a plan required to provide a copy of an internal rule, guideline, protocol, or similar criterion when the applicable rule, guideline, protocol, or criterion was developed by a third party which, for proprietary reasons, limits the disclosure of that information?

Yes. It is the view of the department that where a rule, guideline, protocol, or similar criterion serves as a basis for making a benefit determination, either at the initial level or upon review, the rule, guideline, protocol, or criterion must be set forth in the notice of adverse benefit determination or, following disclosure of reliance and availability, provided to the claimant upon request. However, the underlying data or information used to develop any such rule, guideline, protocol, or similar criterion would not be required to be provided in order to satisfy this requirement. The department also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute instruments under which a plan is established or operated within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries. See §§ 2560.503-1(g)(v) (A) and (j)(5)(i); 65 FR at 70251. Also see §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)(i); Advisory Opinion 96-14A (July 31, 1996).

[61] 29 CFR 1002. For a discussion of the term "participant", see Firestone Tire & Rubber v. Bruch, 489 U.S. 101 (1989).
[62] See 29 U.S.C. §§ 1024(b)(4), 1132(c)(1) and 29 CFR 2520.104b-1.
[63] See PWBA Opinions 79-82A and 82-21A.

Welfare Benefits Administration (PWBA), Office of Regulations and Interpretations, Opinion 96-14A.[64] In this Opinion, the requestor asks whether a schedule of "usual and customary" fees must be made available for examination by the plan administrator upon the request of the plan participant. The Office of Regulations and Interpretations found that the schedule of "usual and customary" fees should be disclosed to a plan participant in accordance with Section 104(b)(2) and 104(b)(4). Specifically, they stated:

> [A]ny document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, *regardless of whether such information is contained in a document designated as the "plan document."* Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan would constitute "instruments under which the plan is . . . operated." [Emphasis added.]

This disclosure right is included in additional departmental guidance on the disclosure of plan documents, which discusses the disclosure of medical necessity criteria related to both MH/SUD and medical/surgical benefits to plan participants. First, after MHPAEA's Interim Final Rule was issued, the Employee Benefits Security Administration (EBSA) published FAQ #11. In FAQ #11, the patient asks what information they are entitled to receive from a plan under MHPAEA. The response, in part, was as follows:

> …[u]nder the Employee Retirement Income Security Act (ERISA), documents with information on the medical necessity criteria for both medical/surgical benefits and mental health or substance use disorder benefits are plan documents, and copies must be furnished within 30 days of your request…[65]

[64] See 78 FR 68248 and PWBA Opinion 96-14A at http://www.dol.gov/ebsa/programs/ori/advisory96/96-14a.htm.
[65] See For Employees about the Mental Health Parity and Addiction Equity Act at http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.

A subsequent FAQ reiterated the previous facts of FAQ #11. In FAQ #10, a patient asks how to obtain information on the medical necessity criteria used for medical/surgical benefits in order to determine whether the plan was applying medical necessity standards more strictly to benefits for MH/SUD treatment than for medical/surgical benefits. The EBSA responded, in part:

> [u]nder ERISA, documents with information on the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits are plan documents, and copies of plan documents must be furnished within 30 days of your request. See ERISA regulations at 29 CFR 2520.104b-1.[66]

Finally, following issuance of MHPAEA's Final Rule, the EBSA issued FAQ #8, which again asks what information the patient is entitled to receive from the plan. The EBSA, once again, states:

> …[u]nder ERISA, documents with information on medical necessity criteria for both medical/surgical and mental health or substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation, are instruments under which the plan is established or operated, and copies must be furnished to a participant […] within 30 days of request...[67]

A review of the Preamble to the Final Rules, the Final Rules, and FAQs reveals that the Departments have addressed the ERISA disclosure requirement as it relates to medical necessity criteria. The right to disclosure of plan documents also affords plan participants (and third parties authorized by them in writing) access to other documents related to plan benefits and not just to documents related to medical necessity criteria.[68] In fact, the purpose of ERISA's disclosure requirement is to protect plan participants' interests in their benefit plans by requiring disclosure and reporting.[69] This disclosure is important to make certain that "the individual participant knows exactly where he stands with respect to the plan."[70] By establishing this disclosure requirement, Congress specifically afforded plan participants the right to

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[66] See FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation at http://www.dol.gov/ebsa/faqs/faq-aca5.html.

[67] See http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.

[68] See PWBA Opinion 96-14A at http://www.dol.gov/ebsa/programs/ori/advisory96/96-14a.htm.

[69] 29 USC 1001.

[70] H.R. Rep. No. 93-533, p. 11 (1973).

review the methods by which a plan is administered in order to give them appropriate information to ensure compliance with ERISA.

b. ERISA Disclosure Right Discussed.

Since MHPAEA amended ERISA and applies to ERISA health plans and benefits, the Section 104 disclosure requirement affords plan participants and their representatives with access to any plan instruments related to MHPAEA compliance so that plan participants can be sure the plan is in compliance with the law and the Final Rules. As is articulated in Opinion 96-14A, this includes any studies, schedules, or similar documents that contain information and data that serve as the basis for determining a participant's benefit entitlements. It would then follow that the right to disclosure under Section 104 would also include information related to financial requirements and treatment limitations (both quantitative and nonquantitative), as well as information related to any compliance review performed by the plan and any data or documentation used in its formation. The imposition of financial requirements and treatment limitations limits a plan participant's benefits under ERISA and any information related to those is subject to the disclosure right.

In addition to instruments under which a plan is established or operated, plan participants also have a right under Section 104 of ERISA to an SPD.[71] This SPD is the primary vehicle used to inform plan participants about their rights and benefits under their employee benefit plan.[72]

c. ERISA Disclosure Recommendations.

Given the guidance set forth above, there are several recommendations for guidance:

i. Clarification and Guidance on the Right to and Depth of Disclosure Under ERISA. The language in the Final Rules specifically addresses the disclosure by an ERISA covered plan of medical necessity criteria under Section 104. While this is helpful in that it highlights a way for plan participants to obtain medical necessity criteria related to medical/surgical benefits prior to an adverse benefit determination, it also

[71] 29 USC 1022.

[72] Id. The SPD must include a description of plan provisions and exclusions (e.g., copayments, deductibles, coinsurance amounts, prior authorization requirements, utilization review requirements, etc.). A link to the plan's network provisions must also be included.

may inadvertently focus health plans on the disclosure of medical necessity criteria and not on ERISA's requirement to disclose other plan documents or instruments (e.g., those documents or instruments related to financial requirements, QTLs, or NQTLs (other than a plan's medical necessity criteria)). Experience would suggest that some health plans see the reminder in the Final Rules as a ceiling on what they must disclose rather than as an example of what they must disclose. Some health plans ask why the information is needed and why the participant wants the information. They see the answer to these questions as relevant to what they are willing to disclose. While the APA does not advocate using the disclosure right as an avenue to seek disclosure of documents that are not directly related to a MHPAEA review, we see the plans' view as a means to overly limit disclosure to participants. Because of this difference in opinion, further regulatory clarification and guidance is necessary to inform ERISA covered health plans that they have an obligation to disclose plan instruments and to guide such plans about the required depth of the disclosure. The APA supports a disclosure right that affords a participant with true transparency regarding his/her plan benefits. True compliance with MHPAEA depends on *complete* transparency of ERISA plan documents and the instruments under which a plan is established or operated. In addition, limiting disclosure so that all relevant plan documents are not disclosed to plan participants is contrary to the Department of Labor's Advisory Opinions and Congressional intent and sets a dangerous precedent that could jeopardize plan participants seeking disclosure for other reasons.

ii. Clarification and Guidance on the Disclosure of the Compliance Review under ERISA. Given the position taken in Opinion 96-14A, plan instruments that must be disclosed include the compliance reviews that the plan has undertaken to ensure that they meet the regulatory tests stipulated by the Final Rules and the studies, schedules, or similar documents that contain information and data that serve as the basis for determining a plan's compliance with federal law, regardless of whether such information is contained in a document or instrument designated as a "plan document." It would be consistent to provide clarifying regulatory or subregulatory guidance on this important point.

A MHPAEA compliance review is required to be performed by a plan and is essential to the establishment and legal operation of a plan. Some plans have admitted that, for a variety of reasons, they have not performed a compliance review. Plans need to be reminded that the compliance review must be performed, and spot audits should be conducted to ensure that it has. Some plans claim it is onerous to have to dig up documents related to financial requirements, QTLs, and NQTLs. However, we do not see this as an onerous

requirement for plans, since, presumably, plans would have already had to conduct a compliance review per the regulatory tests. Therefore, the compliance review should be readily available, along with the data and documentation used to develop it. Further, plans need to be reminded that all plan documents and instruments must be disclosed to plan participants as required by ERISA.

iii. Clarification and Guidance on Disclosure in Lieu of a Claim. Entitlement to requesting plan documents pursuant to ERISA 104(b) is not dependent on an actual claim being made or denied. However, there appears to be some confusion as to what triggers a plan's obligation to disclose. We request an FAQ or other clarifying guidance that provides a scenario illustrating entitlement to the documents in the absence of a claim for benefits or adverse determination.

iv. Reminder and Clarification on the Right of a Plan Participant's Representative to Request Plan Documents and Instruments. As is the position taken by the PWBA in Opinions 79-82A and 82-21A, representatives of plan participants are entitled to obtain disclosure of plan documents with the appropriate written authorization. It is important to issue a reminder on this point as well and to provide some guidance on what should be accepted as valid authorization.

v. Clarification on Point of Contact. It is also essential to clarify the responsible party to whom plan participants can write in order to obtain this information.

The Affordable Care Act.

a. The Law and the Final Rules.

The Preamble to the Final Rules, in its footnotes, highlights provisions of the ACA that require plans to disclose information related to plan descriptions.[73] The ACA gives individuals the right to obtain a simple and easy-to-understand summary about a health plan's benefits. Insurance companies and group health plans must provide individuals with a short, plain-language SBC and a Uniform Glossary of terms used in health coverage and medical care. This summary includes: (i) a description of the coverage for each category of benefits; (ii) the exceptions, reductions, and limitations on coverage; and (iii) the cost-sharing provisions of the coverage (which include

[73] See 26 CFR 54.9815-2715(a)(2)(i) [IRS], 29 CFR 2590.715-2715(a)(2)(i) [EBSA], and 45 CFR 147.200(a)(2)(i) [HHS]. See also the Final Rules regarding SBCs at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-14559.pdf.

deductibles, co-insurance, and copayment obligations).[74] Under the ACA requirements, plans are required to provide contact information (i.e., persons or internet addresses) to obtain the information required in the SBC.[75]

b. Summary of Benefits and Coverage Discussed.

While these provisions of the ACA do not entitle individuals to copies of medical necessity criteria, they do allow an individual (whether or not a participant) to see what financial requirements and treatment limitations (both quantitative and nonquantitative) the plan is imposing on its MH/SUD and medical/surgical benefits in summary form. Nevertheless, it has been our experience that consumers still lack meaningful information necessary to make an informed choice regarding their health benefits. A recent survey conducted by the National Alliance on Mental Illness (NAMI) on mental health parity reported similar findings.[76] NAMI reported that, generally, SBCs do not include the detail necessary for consumers to make an informed selection (e.g., accurate provider lists). NAMI also found that where more detailed information was available, it was complicated and lacked adequate detail.[77] Incomplete disclosure, intentional or otherwise, opens the door for plans to play selection games with potential enrollees.

c. Summary of Benefits and Coverage Recommendations.

Given the guidance set forth above, there are several areas that require resolution:

i. Review of SBC Detail. It is clear the intent of the SBC provisions is to ensure that consumers receive a concise document, detailing in plain language, simple and consistent information about health plan benefits and coverage. However, based on experience, further review of the SBCs that have been developed by plans is necessary to assess whether they are actually providing relevant details respecting the MH/SUD benefits.

ii. Review and Determine How to Provide Parallel Right of Access. While an SBC should provide a participant or beneficiary with a concise summary of coverage requirements, limitations of coverage, and cost-sharing

[74] Id. For a sample SBC, see https://www.cms.gov/CCIIO/resources/files/downloads/sbc-sample.pdf.
[75] Id.
[76] See http://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead.
[77] Id at 11-12.

provisions, it does not give a participant or beneficiary enough information to actually assess compliance with MHPAEA. For example, assume a plan participant is covered by an exchange plan and is seeing a psychiatrist who suddenly terminates his participation agreement with the plan. The psychiatrist explains to the plan participant that he is unhappy with the onerous paperwork requirements imposed by the plan that in-network medical/surgical providers are not required to abide by. However, in this example, there are no disclosure requirements for exchange plans similar to the ERISA disclosure requirements that would provide the plan participant with access to enough information to review compliance with MHPAEA. Health exchange plans and non-federal governmental health plans are not subject to ERISA disclosure requirements. It is important for a plan participant to have the same access to plan documents as a plan participant in an ERISA health plan. The Departments should review and determine how to provide plan participants and beneficiaries not covered by an ERISA plan with a parallel right of access.

iii. Require SBCs to Represent That They are in Compliance. The SBC should represent that the plan is in compliance with MHPAEA . The Departments should require plans to state in their SBCs that their plans are in compliance with the law and its rules and that they have conducted the necessary compliance review to confirm such compliance.

iv. Review and Discuss Contact Information. The SBC requirements call for the provision of contact information regarding plan details. This may be a person or an internet address. Navigating plan websites and discovering the appropriate link or person to call often proves difficult, defeating the purpose of the requirement. This needs further review and discussion regarding what recommendations should be made.

2. Disclosure Under Claims Procedure and Internal Claims and Appeals and External Review Processes Regulations.

a. The Law and the Final Rules.

The laws and regulations discussed below entitle participants and beneficiaries to the disclosure of information related to their MH/SUD and medical/surgical benefits after the plan has made an adverse benefit determination. Disclosure of plan information can be obtained under almost all plans after such a determination has been rendered.

The Final Rules remind readers of the right to disclosure of medical necessity criteria and other plan information related to medical/surgical benefits under federal regulations as follows:

> …§§ 2560.503-1 and 2590.715-2719 of this chapter set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.[78]

Pursuant to the claims procedure and internal claims and appeals and external review processes regulations, a claimant has the right to access copies of all documents, records, and other information relevant to a claim for benefits.[79] This includes, but is not limited to, the medical necessity criteria related to MH/SUD and medical/surgical benefits following an adverse benefit determination.[80] The information to be provided by a plan administrator or health insurance issuer must be documents of a comparable nature with information on medical necessity for both MH/SUD and medical/surgical benefits (including processes, strategies, evidentiary standards, and other facts used to apply NQTLs).[81]

Guidance on the disclosure of medical necessity criteria following an adverse benefit determination is supported by subregulatory guidance issued by the

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[78] 29 CFR 2590.712(d)(3).

[79] See 29 CFR 2560.503-1(h)(2)(iii), which provides that a plan's claims procedures must:

> Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section[.]

[80] 29 CFR 2590.712(d)(3).

[81] See 78 FR 68247-68248.

EBSA. First, after MHPAEA's Interim Final Rules were issued, the EBSA published FAQ #11 (described above). Following the patient's question about what information they are entitled to receive from a plan under MHPAEA, the EBSA responded as follows:

> …the individual (or a provider or other individual acting as a patient's authorized representative) may request these documents consistent with the Department of Labor claims procedure regulation (and, if the plan is a non-grandfathered health plan, the external review requirements added by the Patient Protection and Affordable Care Act would apply).[82]

In FAQ #8, issued following the Final Rules, it is asked what information the patient is entitled to receive from the plan. The EBSA again advises:

> [U]nder the internal appeals and external review requirements added by the Affordable Care Act, non-grandfathered group health plans and health insurance issuers must provide to an individual (or a provider or other individual acting as a patient's authorized representative), upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the individual's claim for benefits consistent with the Department of Labor claims procedure regulation.(7) This includes documents of a comparable nature with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. In addition, the plan or issuer must provide the claimant with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with a claim. If the plan or issuer is issuing an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale.[83]

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[82] See For Employees about the Mental Health Parity and Addiction Equity Act at http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.
[83] See http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.

Finally, the Self-Compliance Tool for Part 7 of ERISA, advising plans on how to achieve compliance of HIPAA, including provisions of MHPAEA, provides as follows:

> If coverage is denied based on medical necessity, medical necessity criteria for the mental health/substance use disorder benefits at issue and for medical/surgical benefits in the same classification must be provided within 30 days of the request to the participant, beneficiary, or provider or other individual if acting as an authorized representative of the beneficiary or participant. See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1); ACA Implementation FAQ Part V, Question 10.

b. Claims Procedure and Internal Claims and Appeals and External Review Processes Regulations Discussed.

The sponsoring Departments' guidance focuses on the fact that medical necessity criteria must be disclosed under Sections 2560.503-1 and 2590.715-2719 so that a claimant can appeal an adverse benefit determination. However, Sections 2560.503-1 and 2590.715-2719 are not limited to the disclosure of medical necessity criteria. Plan participants and beneficiaries are entitled to information relevant to an appeal from an adverse benefit determination challenging MHPAEA compliance, whether the challenge is related to financial requirements or treatment limitations, a plan's medical necessity criteria, as written or applied, or otherwise.

c. Claims Procedure and Internal Claims and Appeals and External Review Processes Regulations Recommendations.

i. **Guidance on the Depth of Disclosure Under the Claims Procedure and Internal Claims and Appeals and External Review Processes Regulations.** Given the foregoing, additional guidance to plans is needed clarifying that Sections 2560.503-1 and 2590.715-2719 apply to the appeals of all adverse benefit determinations related to MHPAEA compliance and not just appeals with respect to medical necessity criteria. This clarification could be done by revising the Self-Compliance Tool to make clear that the disclosure requirements related to MHPAEA go beyond denials of coverage based on medical necessity criteria.

ii. **Guidance on How to Initiate Appeals.** Plan participants and beneficiaries need more transparent guidance on how to initiate an appeal that challenges MHPAEA compliance. It is important that

materials are available to plan participants and beneficiaries that educate them and provide the steps of the process by which to challenge their claim denials.

iii. **Review Issue of Proprietary Excuse.** As discussed above, plans often do not disclose information that they deem "proprietary" or "commercially valuable. " There is no exception in the regulations for information that is "proprietary" or "commercially valuable." However, the sponsoring departments have, at times, taken the position that there should be a balancing of interests, which has allowed plans to avoid disclosure to some degree. It should be noted that ERISA plan participants have the right to obtain plan information that is deemed "proprietary" or "commercially available" under Section 104(b). The departments should review this issue and provide guidance on it in a manner that protects all patients and gives all patients the same right to access that ERISA plan participants have.

iv. **Guidance on Contact Person and Information.** Access to plan information after an adverse benefit determination is essential. However, it is often difficult for participants and beneficiaries to determine the appropriate contact and locate contact information. Plans should be required to provide relevant information regarding a contact person, who is actually available during business hours, and e-mail address and telephone numbers for the contact person should be provided to ensure appropriate disclosure of information to a plan participant and beneficiary.

4) ***The Internal Claims and Appeals and External Review Procedures Entitle Plan Participants, Beneficiaries, or Authorized Representatives to Seek External Review of an Adverse Benefit Determination on the Basis of MHPAEA Compliance and Obtain All Needed Information Through Disclosure.***

a. The Law and the Final Rules.

The Interim Final Rules for the Internal Claims and Appeals and External Review Procedures[84] provide that certain participants, beneficiaries, and authorized representatives are entitled to seek review of an adverse benefit determination if it is believed that there may be a violation of MHPAEA and allow the claimant to obtain relevant information related to a review.[85] The Interim Final Rules state that the scope of claims eligible for external review for plans using a federal external review process includes claims that involve medical judgment. Examples of situations in which a claim is considered to involve *medical judgment* include adverse benefit determinations based on:

> whether a plan is complying with the nonquantitative treatment limitation provisions of MHPAEA and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.[86]

Therefore, individuals have the right to challenge an adverse benefit decision based on a potential lack of compliance with MHPAEA and receive all necessary information related to such a challenge. This would include the plan's compliance review and supporting documentation, studies, etc. that an individual would need to challenge the denial on the basis of compliance, whether it be an internal appeal or external appeal with an independent review entity.

b. The Internal Claims and Appeals and External Review Procedures Discussed.

The Interim Final Rules for the Internal Claims and Appeals and External Review Procedures make an important distinction. While a health plan may be applying medical necessity criteria appropriately, those criteria may not comply, or the protocol used to implement the criteria may not comply with the law. Therefore, it is important for plan participants and beneficiaries to be able to challenge a health plan's financial requirements and treatment

[84] 76 FR 37208.
[85] See 29 CFR 2590.715-2719.
[86] See 76 FR 37216.

limitations that do not comply with the law when they are integral to the denial of benefits.

Ensuring appropriate access by claimants to all relevant information related to a challenge of compliance, including financial requirements, QTLs, and NQTLs (not just medical necessity criteria), any processes, strategies, evidentiary standards, and other factors used in applying NQTLs to benefits, and any analysis, studies, or supporting documentation is critical for plan participants and beneficiaries to seek compliance with MHPAEA.

We ask the Department to do the following:

i. Claimants should be notified of their right to challenge an adverse benefit determination on the basis of MHPAEA. Current notice requirements should be revised to effect this and the Model Notices should be updated to reflect this change.

ii. Once notified of their right to challenge an adverse benefit determination based on a MHPAEA compliance issue, it is important that a plan participant or beneficiary be educated on how to do this. Regulatory and subregulatory guidance making this a viable option is important.

iii. Since it is not clear that an IRO has the right to disclosure if a MHPAEA claim is asserted, it should be made clear whether or not the independent review entities also have the right to ask for disclosure of plan documents where there is a material MHPAEA issue raised in an external review. If an IRO has a right to disclosure, what disclosure is an IRO entitled to when a benefit denial is challenged on the basis of MHPAEA?

iv. The sponsoring Departments should review how IROs do or should review and analyze a MHPAEA compliance challenge. Are there mechanisms in place that would ensure that an IRO has adequate training and the ability to receive all information necessary to review an appeal on the basis of a MHPAEA compliance challenge? Based on the attached Order In the Matter of Petitioner v. United Healthcare Insurance Company, issued and entered on March 24, 2015, we are concerned that IROs do not have the knowledge necessary to review an appeal based on a MHPAEA compliance challenge or the knowledge that they can review such challenges. We are also concerned that States are not aware that MHPAEA compliance issues are to be review upon appeal to an IRO.

5) MHPAEA Requires Health Plans and Health Insurance Issuers to Ensure that their Plan is in Compliance with MHPAEA When it Uses Contractors to Administer or Manage their MH/SUD Benefits.

a. The Law and the Final Rules.

Many health plans contract with MBHOs or similar entities to administer or manage their MH/SUD benefits.[87] Prior to MHPAEA and the Final Rules, MBHOs operated separately from the plans they contracted with and did not have to coordinate benefits, financial requirements, and treatment limitations with the underlying health plan, nor did they have to coordinate efforts to disclose information to plan participants, beneficiaries, providers and/or authorized representatives. However, following MHPAEA and the Final Rules, MBHOs and the underlying health plans must coordinate the benefits, financial requirements, and treatment limitations and comply with all of the requirements of MHPAEA and the Final Rules, including all of the disclosure requirements, as if they were one plan.[88] Entities that once managed and administered benefits separately now must work together to ensure MHPAEA compliance across benefits. This would include the preparation and performance of a compliance review that demonstrates that the plan and the MBHO's efforts are coordinated in a manner so that the benefits and any limitations on the benefits comply with MHPAEA. The fact that they are separate entities does not alleviate the requirement to prepare a compliance review of the plan benefits, financial requirements, and treatment limitations as a whole and be in compliance with the law and its regulations. Despite its contract with a third party, the underlying health plan remains ultimately responsible for ensuring compliance with the law and the Final Rules and for any violation thereof.[89]

Both the Preamble to MHPAEA's Interim Final Rules and MHPAEA's Final Rules specifically addresses this issue. The Interim Final Rules state:

> The Departments expect that group health plans and health insurance issuers will conduct a compliance review to ensure that their plan documents, summary plan descriptions, and any associated policies and procedures comply with the requirements of MHPAEA and these regulations.[90]

[87] 78 FR 68250.
[88] Id. See also 29 CFR 2590.712(e).
[89] Id.
[90] 75 FR 5426

The Final Rules expand on this compliance review requirement by providing as follows:

> The coverage as a whole must still comply with the applicable provisions of MHPAEA, and the responsibility for compliance rests on the group health plan and/or the health insurance issuer, depending on whether coverage is insured or self-insured. This means that the plan or issuer will need to provide sufficient information in terms of plan structure and benefits to the MBHO to ensure that the mental health and substance use disorder benefits are coordinated with the medical/surgical benefits for purposes of compliance with the requirements of MHPAEA. Liability for any violation of MHPAEA rests with the group health plan and/or health insurance issuer.[91]

The Preamble to both MHPAEA's Interim Final Rules and its Final Rules specifically state that the plan as a whole is expected to perform a compliance review in order to ensure compliance with the law and its implementing regulations.[92] The Preamble to the Final Rules further clarifies that this analysis does not need to be repeated unless there is a change in the plan benefit design, cost-sharing structure, or utilization that would affect a financial requirement or treatment limitation within a classification or sub-classification.[93]

b) Coordination of Compliance Discussed.

While both the Preamble to the Interim Final Rules and the Preamble to the Final Rules make it unequivocally clear that health plans and health insurance issuers must share information and perform a compliance review in order to determine whether the plan "as a whole" is in compliance with MHPAEA, based on discussions with MHBOs, many have indicated that a compliance review has not been performed and health plans have not provided them with appropriate documentation necessary to do so. It is, therefore, open to question whether many plans with MBHO arrangements are, in fact, in compliance with the law and the Final Rules. This is contrary to the legal obligation to work together to ensure compliance with MHPAEA, leaving plan participants and beneficiaries without medically necessary MH/SUD treatment.

Based on discussions with plans and MBHOs, it is our understanding that many arrangements between employers, plans, and MBHOs do not ensure an appropriate exchange of benefits information or the coordination of an analysis or review of plan

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[91] Id.
[92] 78 FR 68250.
[93] 78 FR 68250.

compliance. As a result, there are a number of arrangements for which an analysis has not been performed and plans may well be out of compliance with the law and the Final Rules. When asked by a participant or beneficiary for a justification of plan compliance or information in order to perform an analysis, many MBHOs merely state that they are in compliance without providing any evidence that this is so. Some say they are compliant even though they have completely different financial requirements and treatment limitations than the underlying plan, and still others say they do not have to coordinate their financial requirements and treatment limitations with the medical/surgical benefits. This would indicate that in some cases, the MBHO is either unaware of the coordination requirement and the requirement that benefits be treated as one plan for the purposes of a compliance analysis or that the MBHO may be raising impossibility as an excuse to avoid compliance with the law and its rules. The fact that some MBHOs and plans admit that they have not done the analyses required by the law and the rules and others admit that they may not be in compliance is troubling at best. Plans should not be able to avoid performing a compliance review by entering into arrangements with contractors and citing impossibility as a defense.

These findings are not just our observations, but are also the observations of the New York Attorney General, who has found, in at least two examples, that MBHOs have not been coordinating the financial requirements and treatment limitations imposed on MH/SUD benefits with the financial requirements and treatment limitations imposed on the medical/surgical benefits administered by the underlying plan.[94] The New York Attorney General has found these arrangements to have resulted in insufficient coverage of behavioral health treatments, more restrictive utilization review techniques, inappropriate cost-sharing arrangements, etc.

In addition, due to the bifurcated nature of the arrangements, it is not always easy for participants and beneficiaries to figure out from whom they need to request information and they are often left searching between the plan and the MBHOs for all kinds of information needed to perform the analysis. The process of obtaining information is cumbersome and difficult. Requests for the disclosure of information are met with varied responses. Some MBHOs state that they simply do not have information related to the medical/surgical benefit in order to disclose it. In these cases, it is very difficult, if not impossible, for participants and beneficiaries to

[94] See Settlements for Excellus, Emblem, Value Options, MVP, and Cigna at http://www.ag.ny.gov/pdfs/Excellus%20Parity%20AOD%20-%20Executed.pdf; http://www.ag.ny.gov/pdfs/2014-07-03-EmblemParity_MR.pdf; http://www.ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf; and http://www.ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/new/2014-03-19%20MVP%20Parity_MR.pdf.

obtain the necessary information related to their MH/SUD and medical/surgical benefits in order to ensure compliance with the law and the rules.

c. Coordination of Compliance Recommendations.

While there are many benefits to plans contracting with MBHOs, these benefits do not outweigh the harm caused by noncompliance. If we are to achieve compliance with the law, these issues need to be addressed. Recommendations to address these issues are:

i. **Instruction to plans that they must coordinate compliance.** Health plans and their MBHOs need a reminder that they are required to share information and to perform an analysis of their benefits as a whole. Health plans also need to be reminded that they are ultimately liable for violations of the law and if necessary, must modify their current arrangements to allow for analysis and compliance.

ii. **Instruction to plans that they have a duty to disclose.** Health plans and their MBHOs (which are service provider organizations to health plans) also need a reminder that, depending upon the circumstances, they have the duty to disclose information related to both MH/SUD and medical/surgical criteria (including their bases for meeting the regulatory tests) to plan participants and beneficiaries in a timely manner. Responses such as "we are in compliance with the law" or "we don't have access to MH/SUD or medical/surgical criteria" are unacceptable. Plans need to see that the sponsoring Departments are serious about this requirement since plans and MBHOs currently readily admit that they have not performed the appropriate analyses.

iii. **One contact point to obtain all information related to both MH/SUD and medical/surgical benefits.** In order for participants and beneficiaries to truly be able to access information, there should be one point of contact to obtain all information necessary for appeals of adverse benefit determinations on the basis of MHPAEA compliance. Guidance should be provided that requires plans and MBHOs to coordinate on this point and provide meaningful and accessible contact information.

iv. **Targeted or random audits to ensure compliance.** There is evidence that a number of MBHOs and health plans have not performed the review necessary to determine compliance with MHPAEA. MBHOs and health plans will continue to avoid compliance with the law unless they are held accountable. We recommend the

sponsoring Departments and states to accelerate efforts to investigate these arrangements to see that plan participants and beneficiaries are getting the benefits they deserve.

Dispute Resolution

There are several possible outcomes under the foregoing disclosure provisions. First, the requesting party may receive no response at all. Second, the requesting party may receive an incomplete response. Third, the requesting party may receive a relatively robust response and believes, on the basis of the disclosed materials, there is a parity issue. How these various situations can and should be handled and any enforcement actions that could be related to these is beyond the scope of this paper, but does require a more detailed exploration and discussion with the responsible federal and state regulatory entities.

States have an important role in enforcing compliance of MHPAEA and its Final Rules. However, many states believe that they do not have the authority to enforce this law and its regulations. States need authoritative guidance on the requirement to enforce and their ability to do so. The Center for Consumer Information and Insurance Oversight (CCIIO) could be helpful in identifying the states that have the authority to enforce MHPAEA compliance and those that do not have the authority.

EXHIBIT A

DISCLOSURE TO PLAN PARTICIPANT/AUTHORIZED REPRESENTATIVE OF AN ERISA COVERED PLAN

WHEN?	BY WHOM?	LAW/REGULATION	INFORMATION DISCLOSED
At any time.	**Any current or potential participant, beneficiary, or contracting provider**	**MHPAEA (29 USC 1185a(a)(4)) and its Final Rules (29 CFR 2590.712(d)(1)**	**Medical necessity criteria related to MH/SUD benefits.** ***ERISA plan participants would most likely use their rights under Section 104(b), as this ERISA right would enable them to get criteria related to their medical/surgical benefits. This would enable then to perform a compliance review.***
At any time	**Plan participant and their authorized representatives**	**ERISA Section 104(b) and regulations at 29 CFR 2520.104b-1.**	**Plan documents and instruments under which a plan is established or operated.** **This would include any documents or reviews related to a plan's financial requirements and treatment limitations (both quantitative and nonquantitative).** **The Final Rules confirm that an**

			"instrument" includes medical necessity criteria related to both MH/SUD and medical surgical benefits and the processes, strategies, evidentiary standards and other factors used to apply the criteria to an NQTL . See 29 CFR 2590.712(d)(3).
At any time.	**Plan participant and their authorized representatives**	**ERISA Section 104(b) and regulations at 29 CFR 2520.104b-1.**	**Summary Plan Description (SPD), which includes the most important plan provisions.**
At any time.	**Health plan participants, beneficiaries, and prospective enrollees.**	**Affordable care Act (29 CFR 2590.715-2715(a)(2)(i)).**	**Summary of Benefits and Coverage (SBC), which includes summary description of benefits and coverage including limitations on benefits and cost-sharing provisions.**
After a claim has been denied.	**Claimants or their authorized representatives.**	**MHPAEA (29 USC 1185a(a)(4), the Final Rules (29 CFR 2590.712(d)(2)), 29 CFR 2560.503-1, and the ACA (29 CFR 2590.715-2719(b)).**	**Specific reason for denial and an appropriate notice of adverse benefit determinations.**
After a claim has been denied.	**Claimants or their authorized representatives.**	**29 CFR 2560.503-1 and the ACA (29 CFR 2590.715-2719(b))**	**Reasonable access to and copies of all documents, records and other information relevant to a claimants claim for benefits.**

			The Final Rules confirm that relevant information includes medical necessity criteria related to both MH/SUD and medical surgical benefits and the processes, strategies, evidentiary standards and other factors used to apply the criteria to an NQTL . See 29 CFR 2590.712(d)(3).

EXHIBIT B

DISCLOSURE TO PARTICIPANT/BENEFICIARY/AUTHORIZED REPRESENTATIVE OF INDIVIDUAL/EXHANGE PLAN

WHEN?	BY WHOM?	LAW/REGULATION	INFORMATION DISCLOSED
At any time.	Any current or potential participant, beneficiary, or contracting provider	MHPAEA (29 USC 1185a(a)(4)) and its Final Rules (29 CFR 2590.712(d)(1)	Medical necessity criteria related to MH/SUD benefits.
At any time.	Health plan participants, beneficiaries, and prospective enrollees.	Affordable care Act (29 CFR 2590.715-2715(a)(2)(i)).	Summary of Benefits and Coverage (SBC), which includes summary description of benefits and coverage including limitations on benefits and cost-sharing provisions.
After a claim has been denied.	Claimants or their authorized representatives.	MHPAEA (29 USC 1185a(a)(4), the Final Rules (29 CFR 2590.712(d)(2)), 29 CFR 2560.503-1, and the ACA (29 CFR 2590.715-2719(b)).	Specific reason for denial and an appropriate notice of adverse benefit determinations.
After a claim has been denied.	Claimants or their authorized representatives.	29 CFR 2560.503-1 and the ACA (29 CFR 2590.715-2719(b))	Reasonable access to and copies of all documents, records and other information relevant to a claimants claim for benefits. The Final Rules confirm that relevant information

			includes medical necessity criteria related to both MH/SUD and medical surgical benefits and the processes, strategies, evidentiary standards and other factors used to apply the criteria to an NQTL . See 29 CFR 2590.712(d)(3).

EXHIBIT C

APA'S RECOMMENDATION TO IMPROVE DISCLOSURE OF HEALTH PLAN INFORMATION

Recommendations for Reason for Denial.

It is essential for plan administrators, health insurance issuers, and claimants (including their authorized representatives) to have additional regulatory or subregulatory guidance that clarifies the additional specificity that a plan administrator or health insurance issuer must provide in an explanation of an adverse benefit determination so that a claimant or their authorized representative will be able to prepare for an appropriate appeal or review. While there is a great deal of guidance for plans (including the model notices), this is an area where plans fall short, and this shortfall thwarts the ability of claimants to obtain medically necessary services, let alone exercise the due process rights given by the regulations. It is also important to have additional regulatory or subregulatory guidance, informing plans and issuers of the requirements for appropriately and timely notifying claimants using all of the required elements of both 29 CFR 2560.503-1 and 29 CFR 2590.715-2719.

Additional recommendations are as follows:

i. **More guidance on the specificity of the actual elements of the notice**. Given the differences in specificity of reasons for denial provided by plan administrators and health insurance issuers, it would be helpful to have more guidance or examples to show plan administrators and health insurance issuers what an appropriate reason for denial should look like. Guidance should also inform plans that the reason for the denial and the information about the appropriate appeal mechanism must be provided in a member-specific way. Notices should not be form driven or include significant boilerplate language.

ii. **Guidance reminding plans to use Model Notices.** Health plans should be reminded that the Departments have issued Model Notices, which are consumer friendly and guide the patient at the appropriate level of review. These models should be more closely followed by health plans, as many health plans currently employ complicated forms and attachments, which do not provide a plain-language explanation of the claim denial and the participant's options for appeal. For example, we have reviewed notices from one plan that attaches a brochure detailing internal appeal and external review options for patients. The brochure has three sections. The first

section directs the patient to review their member card and determine, based on the numbers and information on the card, what type of coverage they have. Once they determine what coverage they have, they are then directed to figure out what their appeal options are and told to read either section 2 of the brochure to learn about internal appeal options or section 3 of the brochure to learn about external review options. This type of brochure is not consumer friendly and may actually frustrate attempts by patients to appeal claims. Furthermore, it is not consistent with the intent of the law and regulations in that it does not provide a patient with specific information regarding the claim denial and exactly how to appeal the denial in their particular circumstances. Given issues with notices of adverse benefit determination, the Departments should do spot audits to ensure that the information contained in the model notices is not only included in plan notices to patients, but is included in a way that is consumer-friendly and easy to understand.

iii. **"Complies with" should replace "consistent with".** The Final Rules state that the reason for the denial must be made in a form and manner *consistent* with the requirements of the claims review procedures set forth in 29 CFR 2560.503-1. The word "consistent" leaves room for interpretation by the plan administrator or health insurance issuer to provide notice that is similar, but not identical, to the notice requirements of 29 CFR 2560.503-1. The regulators should make clear that the notice requirements of 29 CFR 2560.503-1 prevail in all cases since this specificity protects patients who wish to appeal adverse benefit determinations. In addition, just as important as 29 CFR 2560.503-1 is 29 CFR 2590.715-2719. The regulations related to internal and external review (i.e., 2590.715-2719) require additional specific information for claimants respecting a reason for denial by a health plan and provide much needed consumer protections. It should be clear that 29 CFR 2590.715-2719 prevails in all cases too.

iv. **Reminder to plans and issuers that it is a regulatory requirement to provide timely notice when using a new rationale in final internal adverse benefit determinations.** Plan participants and beneficiaries are finding it difficult to respond and appeal final internal adverse benefit determinations when they do not receive notice of a new rationale being used by plans in denying benefits in a timely manner. This notice is essential to ensuring access, especially in the case of urgent claims for medically necessary benefits, and plans should be informed of its importance and required to comply. A reminder regarding these requirements would be helpful.

v. **Guidance requiring plans and issuers to make e-mail contacts and telephone numbers for plan representatives readily available to plan participants and beneficiaries.** Plans should make specific and dedicated e-mail and telephone contact information available to plan participants and beneficiaries so they can ask questions and obtain file and other information in a timely manner to prepare for reviews and appeals. It is not adequate to merely give a general member services number, which has numerous recorded messages and prompts to find the correct party.

Recommendations for Disclosure of MH/SUD Medical Necessity Criteria.

The following issues with respect to Section (d)(1) of the Final Rules need to be addressed

i. **Definition of Medical Necessity Criteria and Requirement to Disclose Processes, Strategies, Evidentiary Standards, and Other Factors Used to Apply an NQTL.** We request that the sponsoring Departments clarify what is meant by the term "medical necessity criteria." Many of the NQTLs illustrated in the Final Rules are part of a plan's medical necessity criteria. For example, we contend that fail-first protocol is assumed to be part of the plan's medical necessity criteria, as it is a core component of the criteria by which the criteria are applied. Some plans would argue, however, that fail-first protocols are not part of the medical necessity criteria and are not disclosable as such. It is our understanding that this interpretation is not consistent with the intent of the Departments. The Departments did not mean to create loopholes for plans to avoid disclosure of information relevant to plan participants and beneficiaries to determinate whether plans cover MH/SUD treatments.

Many health plans hold the view that since Section (d)(1) of the Final Rules does not mention anything except the medical necessity criteria related to the MH/SUD benefit and does not specifically require the disclosure of anything else, including the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, they do not have to disclose any other information, including the processes, strategies, evidentiary standards or other factors used to apply the medical necessity criteria. While we acknowledge that the sponsoring Departments do not specifically refer to the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, by definition, the processes, strategies, evidentiary standards, and other factors may be embedded within medical necessity criteria and, therefore, should be subject to the disclosure requirement. For example, medical necessity criteria could be applied using a medical management

protocol (e.g., prior authorization or concurrent review). This type of information is essential to a beneficiary or participant in understanding how the protocol is applied to their benefits. As a result, regulatory guidance should be issued confirming that health plans must disclose the processes, strategies, evidentiary standards, and other factors used to apply an NQTL along with the medical necessity criteria related to MH/SUD benefits.

ii. **Requirement to Disclose Medical Necessity Criteria Related to the Medical/Surgical Benefits and Other Plan Instruments.** Section (d)(1) of the Final Rules does not provide that a potential or current plan participant, beneficiary, or contracting provider can obtain medical necessity criteria related to the medical/surgical benefits. While a number of potential or current plan participants can obtain medical necessity criteria related to medical/surgical criteria under ERISA Part 104, those current or potential plan participants and beneficiaries not covered by an ERISA plan (e.g., individual plans and ACA exchange plans) and contracting providers cannot obtain these criteria absent an adverse benefit determination. As a result of this, while these individuals can review the medical necessity criteria related to MH/SUD benefits, they cannot obtain enough meaningful information to perform a compliance review of their benefits as a whole. We ask the Departments to review this shortfall and seek to afford all plan participants, beneficiaries, and contracting providers with the information necessary to ensure compliance with MHPAEA and the Final Rules. There should be a meaningful way for all individuals to assess plan compliance in lieu of a claims denial.

iii. **Requirement to Disclose Information Related to Other NQTLs.** While Section (d)(1) affords current and potential participants, beneficiaries, and contracting providers the ability to obtain medical necessity criteria related to MH/SUD benefits, it does not afford them the opportunity to review information related to other NQTLs (e.g., network tier design; formulary design for prescription drugs; standards for provider admission to participate in a network; plan standards for determining usual, customary, and reasonable standards; fail-first policies and step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that would limit the scope or duration of benefits). All NQTLs, by definition, limit the scope and duration of the MH/SUD benefit. Without disclosure of all NQTLs, a current or potential participant, beneficiary, or contracting provider cannot truly understand a plan's MH/SUD benefits. We also ask the Departments to review this shortfall and seek to afford all plan participants, beneficiaries, and contracting providers

with the necessary information to ensure compliance with the law and the rules. Transparency is necessary to ensure compliance. Our recommendation is supported by FAQ #C-17. *See footnote 56.*

iv. **Clarification on the Disclosure of Medical Necessity Criteria that May be Deemed Proprietary or Commercially Valuable by the Health Plan.** Our experience would suggest that a number of health plans state that they cannot disclose medical necessity criteria that they deem proprietary, "commercially valuable," or subject to a vendor agreement. There is no regulatory or other guidance related to MHPAEA that permits plans to avoid disclosure by citing the proprietary, commercially valuable, or contractual nature of their criteria. Guidance to address the ability of health plans to avoid disclosure by asserting that their criteria is proprietary, commercially valuable, or provided through a vendor arrangement is important.

v. **Clarification that Health Plans Must Disclose All of the Criteria.** Our experience also suggests that a number of health plans refer those requesting medical necessity criteria to a website that provides a summary of the criteria, but not all of the criteria. This falls short of meeting the regulatory requirement. Guidance to clarify that health plans must disclose the all of the medical necessity criteria and how they are applied to the requester's MH/SUD benefits is necessary.

vi. **Guidance on Timeline for Disclosure.** While MHPAEA requires plan administrators and health insurance issuers to provide medical necessity criteria related to MH/SUD benefits upon request, there is no guidance regarding the time frame in which they must provide the criteria to the requestor. While this may seem technical, it is necessary to discuss and provide for an appropriate time frame. Without such guidance, a plan administrator or health insurance issuer does not have to provide the criteria in a timely manner. Please note that ERISA plan participants are entitled to request these criteria under ERISA Section 104(b) regulations on disclosure of plan documents, which must be provided within 30 days.

vii. **Requirement to Provide Responsible Party for Disclosure.** If a plan has contracted with a managed behavioral healthcare organization (MBHO) to administer or manage the MH/SUD benefit, the plan should be required to make it clear who the current or potential participant, beneficiary or contracting provider should contact for the appropriate MH/SUD medical necessity criteria. Likewise, if self-funded, the plan should be required to make it clear who is responsible (i.e., the named plan administrator or the entity managing the plan). Furthermore, if the individual is in a plan that is contracting with an MBHO, the plan should be required to make it clear who

they should ask for this information. There is considerable confusion about who, in fact, is the responsible party for disclosure.

viii. **Arrangements Should be Made to Ensure that Participants Obtain Criteria.** Plans should be required to make appropriate arrangements with MBHOs to access medical necessity criteria related to MH/SUD benefits, so that the criteria can be provided to requesting participants or MBHOs should be required to release the information directly to the participants pursuant to the Final Rules.

ix. **Plans Should Provide Appropriate Contact Information**. Plans should be required to provide relevant information regarding an appropriate contact person and the e-mail address and telephone numbers for that contact person to ensure that the appropriate disclosure of information to a plan participant or beneficiary can be accomplished.

x. **Clarification of Required Documentation for Authorized Representative.** There also needs to be clarification of what is acceptable documentation to confirm that someone is acting in an authorized representative capacity, namely legally sufficient forms, as opposed to only the plan's internal form.

ERISA Disclosure Recommendations.

There are several recommendations for guidance:

i. **Clarification and Guidance on the Right to and Depth of Disclosure Under ERISA.** The language in the Final Rules specifically addresses the disclosure by an ERISA covered plan of medical necessity criteria under Section 104. While this is helpful in that it highlights a way for plan participants to obtain medical necessity criteria related to medical/surgical benefits prior to an adverse benefit determination, it also may inadvertently focus health plans on the disclosure of medical necessity criteria and not on ERISA's requirement to disclose other plan documents or instruments (e.g., those documents or instruments related to financial requirements, QTLs, or NQTLs (other than a plan's medical necessity criteria)). Experience would suggest that some health plans see the reminder in the Final Rules as a ceiling on what they must disclose rather than as an example of what they must disclose. Some health plans ask why the information is needed and why the participant wants the information. They see the answer to these questions as relevant to what they are willing to disclose. While the APA does not advocate using the disclosure right as an avenue to seek disclosure

of documents that are not directly related to a MHPAEA review, we see the plans' view as a means to overly limit disclosure to participants. Because of this difference in opinion, further regulatory clarification and guidance is necessary to inform ERISA covered health plans that they have an obligation to disclose plan instruments and to guide such plans about the required depth of the disclosure. The APA supports a disclosure right that affords a participant with true transparency regarding his/her plan benefits. True compliance with MHPAEA depends on *complete* transparency of ERISA plan documents and the instruments under which a plan is established or operated. In addition, limiting disclosure so that all relevant plan documents are not disclosed to plan participants is contrary to the Department of Labor's Advisory Opinions and Congressional intent and sets a dangerous precedent that could jeopardize plan participants seeking disclosure for other reasons.

ii. **Clarification and Guidance on the Disclosure of the Compliance Review under ERISA.** Given the position taken in Opinion 96-14A, plan instruments that must be disclosed include the compliance reviews that the plan has undertaken to ensure that they meet the regulatory tests stipulated by the Final Rules and the studies, schedules, or similar documents that contain information and data that serve as the basis for determining a plan's compliance with federal law, regardless of whether such information is contained in a document or instrument designated as a "plan document." It would be consistent to provide clarifying regulatory or subregulatory guidance on this important point.

A MHPAEA compliance review is required to be performed by a plan and is essential to the establishment and legal operation of a plan. Some plans have admitted that, for a variety of reasons, they have not performed a compliance review. Plans need to be reminded that the compliance review must be performed, and spot audits should be conducted to ensure that it has. Some plans claim it is onerous to have to dig up documents related to financial requirements, QTLs, and NQTLs. However, we do not see this as an onerous requirement for plans, since, presumably, plans would have already had to conduct a compliance review per the regulatory tests. Therefore, the compliance review should be readily available, along with the data and documentation used to develop it. Further, plans need to be reminded that all plan documents and instruments must be disclosed to plan participants as required by ERISA.

iii. **Clarification and Guidance on Disclosure in Lieu of a Claim.** Entitlement to requesting plan documents pursuant to ERISA 104(b) is not dependent on

an actual claim being made or denied. However, there appears to be some confusion as to what triggers a plan's obligation to disclose. We request an FAQ or other clarifying guidance that provides a scenario illustrating entitlement to the documents in the absence of a claim for benefits or adverse determination.

iv. **Reminder and Clarification on the Right of a Plan Participant's Representative to Request Plan Documents and Instruments.** As is the position taken by the PWBA in Opinions 79-82A and 82-21A, representatives of plan participants are entitled to obtain disclosure of plan documents with the appropriate written authorization. It is important to issue a reminder on this point as well and to provide some guidance on what should be accepted as valid authorization.

v. **Clarification on Point of Contact.** It is also essential to clarify the responsible party to whom plan participants can write in order to obtain this information.

Summary of Benefits and Coverage Recommendations.

Given the guidance set forth above, there are several areas that require resolution:

i. **Review of SBC Detail.** It is clear the intent of the SBC provisions is to ensure that consumers receive a concise document, detailing in plain language, simple and consistent information about health plan benefits and coverage. However, based on experience, further review of the SBCs that have been developed by plans is necessary to assess whether they are actually providing relevant details respecting the MH/SUD benefits.

ii. **Review and Determine How to Provide Parallel Right of Access.** While an SBC should provide a participant or beneficiary with a concise summary of coverage requirements, limitations of coverage, and cost-sharing provisions, it does not give a participant or beneficiary enough information to actually assess compliance with MHPAEA. For example, assume a plan participant is covered by an exchange plan and is seeing a psychiatrist who suddenly terminates his participation agreement with the plan. The psychiatrist explains to the plan participant that he is unhappy with the onerous paperwork requirements imposed by the plan that in-network medical/surgical providers are not required to abide by. However, in this example, there are no disclosure requirements for exchange plans similar to the ERISA disclosure requirements that would provide the plan participant with access to enough information to review compliance with MHPAEA.

Health exchange plans and non-federal governmental health plans are not subject to ERISA disclosure requirements. It is important for a plan participant to have the same access to plan documents as a plan participant in an ERISA health plan. The Departments should review and determine how to provide plan participants and beneficiaries not covered by an ERISA plan with a parallel right of access.

iii. **Require SBCs to Represent That They are in Compliance.** The SBC should represent that the plan is in compliance with MHPAEA. The Departments should require plans to state in their SBCs that their plans are in compliance with the law and its rules and that they have conducted the necessary compliance review to confirm such compliance.

iv. **Review and Discuss Contact Information.** The SBC requirements call for the provision of contact information regarding plan details. This may be a person or an internet address. Navigating plan websites and discovering the appropriate link or person to call often proves difficult, defeating the purpose of the requirement. This needs further review and discussion regarding what recommendations should be made.

Claims Procedure and Internal Claims and Appeals and External Review Processes Regulations Recommendations.

i. **Guidance on the Depth of Disclosure Under the Claims Procedure and Internal Claims and Appeals and External Review Processes Regulations.** Given the foregoing, additional guidance to plans is needed clarifying that Sections 2560.503-1 and 2590.715-2719 apply to the appeals of all adverse benefit determinations related to MHPAEA compliance and not just appeals with respect to medical necessity criteria. This clarification could be done by revising the Self-Compliance Tool to make clear that the disclosure requirements related to MHPAEA go beyond denials of coverage based on medical necessity criteria.

ii. **Guidance on How to Initiate Appeals.** Plan participants and beneficiaries need more transparent guidance on how to initiate an appeal that challenges MHPAEA compliance. It is important that materials are available to plan participants and beneficiaries that educate them and provide the steps of the process by which to challenge their claim denials.

iii. **Review Issue of Proprietary Excuse.** As discussed above, plans often do not disclose information that they deem "proprietary" or "commercially valuable. "There is no exception in the regulations for information that is

"proprietary" or "commercially valuable." However, the sponsoring departments have, at times, taken the position that there should be a balancing of interests, which has allowed plans to avoid disclosure to some degree. It should be noted that ERISA plan participants have the right to obtain plan information that is deemed "proprietary" or "commercially available" under Section 104(b). The departments should review this issue and provide guidance on it in a manner that protects all patients and gives all patients the same right to access that ERISA plan participants have.

iv. **Guidance on Contact Person and Information.** Access to plan information after an adverse benefit determination is essential. However, it is often difficult for participants and beneficiaries to determine the appropriate contact and locate contact information. Plans should be required to provide relevant information regarding a contact person, who is actually available during business hours, and e-mail address and telephone numbers for the contact person should be provided to ensure appropriate disclosure of information to a plan participant and beneficiary.

The Internal Claims and Appeals and External Review Procedures Discussed.

The Interim Final Rules for the Internal Claims and Appeals and External Review Procedures make an important distinction. While a health plan may be applying medical necessity criteria appropriately, those criteria may not comply, or the protocol used to implement the criteria may not comply with the law. Therefore, it is important for plan participants and beneficiaries to be able to challenge a health plan's financial requirements and treatment limitations that do not comply with the law when they are integral to the denial of benefits.

Ensuring appropriate access by claimants to all relevant information related to a challenge of compliance, including financial requirements, QTLs, and NQTLs (not just medical necessity criteria), any processes, strategies, evidentiary standards, and other factors used in applying NQTLs to benefits, and any analysis, studies, or supporting documentation is critical for plan participants and beneficiaries to seek compliance with MHPAEA.

We ask the Department to do the following:

i. Claimants should be notified of their right to challenge an adverse benefit determination on the basis of MHPAEA. Current notice requirements should be revised to effect this and the Model Notices should be updated to reflect this change.

ii. Once notified of their right to challenge an adverse benefit determination based on a MHPAEA compliance issue, it is important that a plan participant or beneficiary be educated on how to do this. Regulatory and subregulatory guidance making this a viable option is important.

iii. Since it is not clear that an IRO has the right to disclosure if a MHPAEA claim is asserted, it should be made clear whether or not the independent review entities also have the right to ask for disclosure of plan documents where there is a material MHPAEA issue raised in an external review. If an IRO has a right to disclosure, what disclosure is an IRO entitled to when a benefit denial is challenged on the basis of MHPAEA?

iv. The sponsoring Departments should review how IROs do or should review and analyze a MHPAEA compliance challenge. Are there mechanisms in place that would ensure that an IRO has adequate training and the ability to receive all information necessary to review an appeal on the basis of a MHPAEA compliance challenge? Based on the attached Order In the Matter of Petitioner v. United Healthcare Insurance Company, issued and entered on March 24, 2015, we are concerned that IROs do not have the knowledge necessary to review an appeal based on a MHPAEA compliance challenge or the knowledge that they can review such challenges. We are also concerned that States are not aware that MHPAEA compliance issues are to be review upon appeal to an IRO.

Coordination of Compliance Recommendations.

While there are many benefits to plans contracting with MBHOs, these benefits do not outweigh the harm caused by noncompliance. If we are to achieve compliance with the law, these issues need to be addressed. Recommendations to address these issues are:

i. **Instruction to plans that they must coordinate compliance.** Health plans and their MBHOs need a reminder that they are required to share information and to perform an analysis of their benefits as a whole. Health plans also need to be reminded that they are ultimately liable for violations of the law and if necessary, must modify their current arrangements to allow for analysis and compliance.

ii. **Instruction to plans that they have a duty to disclose.** Health plans and their MBHOs (which are service provider organizations to health plans) also need a reminder that, depending upon the circumstances, they have the duty to disclose information related to both MH/SUD and medical/surgical criteria (including their bases for meeting the regulatory tests) to plan

participants and beneficiaries in a timely manner. Responses such as "we are in compliance with the law" or "we don't have access to MH/SUD or medical/surgical criteria" are unacceptable. Plans need to see that the sponsoring Departments are serious about this requirement since plans and MBHOs currently readily admit that they have not performed the appropriate analyses.

iii. **One contact point to obtain all information related to both MH/SUD and medical/surgical benefits.** In order for participants and beneficiaries to truly be able to access information, there should be one point of contact to obtain all information necessary for appeals of adverse benefit determinations on the basis of MHPAEA compliance. Guidance should be provided that requires plans and MBHOs to coordinate on this point and provide meaningful and accessible contact information.

iv. **Targeted or random audits to ensure compliance.** There is evidence that a number of MBHOs and health plans have not performed the review necessary to determine compliance with MHPAEA. MBHOs and health plans will continue to avoid compliance with the law unless they are held accountable. We recommend the sponsoring Departments and states to accelerate efforts to investigate these arrangements to see that plan participants and beneficiaries are getting the benefits they deserve.

EXHIBIT D

MHPAEA AND OTHER LAWS REQUIRING DISCLOSURE OF INFORMATION

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations (the Final Rules) provide for transparency and disclosure of information through its "Availability of Plan Information" provisions. In addition, there are other laws that require the disclosure of information related to health plan benefits. These laws and regulations require the disclosure of information prior to and after the time a claim is filed by a beneficiary or an alternative benefit determination is issued by a plan.

Regardless of whether a claim is filed or a decision is made by a plan regarding a claim, plan participants, beneficiaries, and contracting providers are entitled to receive information regarding plan benefits. For example, if plan participants in a health plan that is covered by ERISA would like to review information related to their health plan benefits, they can request the disclosure of plan information and/or a Summary Plan Description under Section 104(b) of ERISA. In addition, almost all participants (including participants in plans covered by ERISA) can obtain and review a Summary of Benefits and Coverage from their plans under provisions of the Affordable Care Act. Finally, for all plans covered by MHPAEA, current and potential participants, beneficiaries, and contracting providers can request and obtain a copy of the medical necessity criteria related to their mental health and substance use disorder benefits pursuant to Section (d)(1) of the Final Rules.

After an adverse benefit determination is issued, plan participants and their authorized representatives can rely on other provisions of law and regulations to obtain necessary information to understand their plan's decision and file an appeal. Specifically, 29 CFR 2560.503-1 and 29 CFR 2590.714-2719 set forth specific requirements related to a denial of a claim for benefits and the disclosure of information related to a claim for benefits. There are also disclosure requirements relating to when a participant or beneficiary seeks an external review of a claim.
The key laws and regulations related to the disclosure of information and their details are described the chart below:

WHAT IS DISCLOSED	WHO DISCLOSES IT	WHAT LEVEL OF DETAIL IS DISCLOSED	TO WHOM IS DISCLOSED
Medical Necessity Criteria (MH/SUD) Basis: 29 USC	Plan administrator or health insurance	All MH/SUD criteria (including purchased/proprietary criteria). 29 CFR 2590.712(d)(1) does not provide for the	Any current or potential participants, beneficiaries, o

WHAT IS DISCLOSED	WHO DISCLOSES IT	WHAT LEVEL OF DETAIL IS DISCLOSED	TO WHOM IS DISCLOSED
1185a(a)(4), 29 CFR 2590.712(d)(1), FAQ #9 of the FAQs About ACA Part V and Mental Health Parity Implementation, and Question #43 of the Self-Compliance Tool.	issuer	disclosure of medical/surgical criteria under this specific provision. See provisions related to disclosure of medical/surgical criteria below.	contracting providers
Reason For Any Denial Of Reimbursement Or Payment For Services With Respect to MH/SUD Benefits Basis: For specific requirements for reasons for denial, see 29 CFR 2560.503-1 and 29 CFR 2590.715-2719(b). See also 29 USC 1185a(a)(4), 29 CFR 2590.712(d)(2), Question 43 of the Self-Compliance Tool, and FAQ #8 from the FAQs about ACA (Part XVII) and Mental Health Parity Implementation.	Plan administrator or health insurance issuer	Section (d)(2) requires that these notices be consistent with 29 CFR 2560.503-1. 29 CFR 2560.503-1 and 29 CFR 2590.715-2719(b) provide as follows: Plan administrator or issuer must provide a specific reason for denial, the denial code and it's meaning, reference to the specific plan provisions on which the determination is based, and a description of the standard used in denying the claim. In addition, the plan administrator or issuer must provide a discussion of the decision in the case of a final internal adverse decision.	Participant, beneficiary, or authorized representative.
Instruments Under Which The Plan Is Established or Operated Basis: 29 CFR 2590.712(d)(3), ERISA section 104(b) and 29 CFR 2520.104b-1. See also Advisory Opinion 96-14A. Additional Guidance found at: FAQ #11 at FAQs For Employees about MHPAEA, FAQ #10 at FAQs about ACA Implementation Part V and Mental Health Parity	Plan Administrator (Is there any circumstance under which a named plan fiduciary is responsible for obtaining and/or disclosing these documents?)	Includes all instruments by which a plan is established or operated. ERISA requires plans to disclose a broad range of documents, including "any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, *regardless of whether such information is contained in a document designated as the 'plan document.'* Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn,	Plan participan and/or their authorized representative. See Opinions 7 82A and 82-21 Plan participan include any employee or former employ who is or may become eligible to receive the benefit. This

WHAT IS DISCLOSED	WHO DISCLOSES IT	WHAT LEVEL OF DETAIL IS DISCLOSED	TO WHOM IS DISCLOSED
Implementation, and FAQ #8 at FAQs For Employees About MHPAEA.		serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan would constitute 'instruments under which the plan is . . . operated.'" See Advisory Opinion 96-14A. This requires disclosure or plan documents including medical necessity criteria for both MH/SUD and medical/surgical benefits (including any processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation, information and data that is used to establish quantitative treatment limitations and financial requirements and plan compliance analyses and document used to develop the analyses.	includes employees who are not enrolled See 29 CFR 100
Reasonable access to and copies of all documents, records, and other information relevant to the claimants claim for benefits Basis: 29 CFR 2560.503-1 and 29 CFR 2590.715-2719. The requirements of 29 CFR 2590.715-2719 were established pursuant to the ACA and is additive to the pre-existing requirements of 29 CFR 2560.503-1. See also 29 CFR 2590.712(d)(3), FAQ #11 at FAQs for Employees about MHPAEA, FAQ #8 at FAQs for Employees about MHPAEA, and the Self-Compliance Tool.	Plan administrators and health insurance issuers	Claimants must be provided "upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits." "This includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as processes, strategies, evidentiary standards and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan." This would require disclosure of all relevant information necessary to appeal a claim on the basis of compliance (e.g., the plan's compliance analysis and all documents used to develop the analysis). Documents must be of a comparable nature with information on medical necessity for both MH/SUD and medical/surgical benefits, including processes, strategies, evidentiary standards, and other facts used to apply NQTLs. See 78 FR 68247-68248.	Claimants or authorized representative
Summary of Benefits and Coverage (SBC) Basis: 26 CFR 54.9815-2715(a)(2)(i) [IRS]; 29	Group health plans and health insurance	Accurate summary description of benefits and coverage under a plan, including (i) a description of the coverage (including cost sharing) for each category of benefits; (ii) the exceptions, reductions and limitations on	Must be provid to health plan participants, beneficiaries,

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CFR 2590.715-2715(a)(2)(i) [EBSA]; and 45 CFR 147.200(a)(2)(i) [HHS]. For a sample SBC, see www.cms.gov/CCIIO/resources/files/downloads/sbc-sample.pdf.	issuers. This includes all plans, including health exchange plans. Must specify a contact person/point to obtain the information from.	coverage; and (iii) the cost-sharing provisions of the coverage (which include deductibles, co-insurance, and copayment obligations).	prospective enrollees, and special enrollee
Summary Plan Description (SPD) Basis: ERISA section 104(b) and 29 CFR 2520.104b-1	Plan administrators	The most important plan provisions.	Covered participants (n covered spouse or dependents)