GROOM LAW GROUP

July 31, 2024

Mr. Richard Reves
Administrator
Office of Information and Regulatory Affairs
Office of Management and Budget
New Executive Office Building
725 17th Street, NW.
Washington, DC 20503

RE: Mental Health Parity and Addiction Equity Act ("MHPAEA") Proposed Rule

Thank you for taking the time to meet with us on July 26, 2024. We appreciate the opportunity to share with your Office and the Departments of Labor, Health and Human Services, and the Treasury (collectively, "Administration") our recommendations for and concerns with the Proposed Rule, "Requirements Related to the Mental Health Parity and Addiction Equity Act," published on August 3, 2023 (88 Fed. Reg. 51552). The Coalition is a unique and broad alliance of stakeholders; through its membership, the Coalition provides mental health and substance use disorder ("MH/SUD") benefits to the vast majority of Americans covered by private health insurance plans, both self-insured and insured. As such, Coalition members represent the largest community of MHPAEA-regulated entities who collectively are responsible for providing and paying for vital, comprehensive, and high-quality MH/SUD coverage for many millions of American families. Our members share the same goal as the Administration: we support promoting access to comprehensive MH/SUD services and have invested significant resources to further this objective.

Last year, this Coalition submitted a detailed comment letter on the Proposed Rule, and our members individually submitted comments on behalf of their respective organizations. This letter addresses some of the key topics we discussed at our July 26 meeting. Specifically, we write to note our concerns associated with the Proposed Rule's economic analysis, the application of the substantially all/predominant test to Non-Quantitative Treatment Limitations ("NQTLs"), the fiduciary certification requirement, and the applicability date.

First, it is critical that the Administration recognizes and accounts for the *actual* burden associated with the new requirements. The Proposed Rule's requirements will substantially increase the time and expenses related to the MHPAEA NQTL documentation requirements, diverting resources which could be better used to improve member-facing resources and services. The Coalition members have devoted *substantial* ongoing resources to ensure that their health plans meet MHPAEA's requirements. These resources have come in different forms. For group

health plans, the expenses have primarily been associated with hiring consultants and/or law firms to assist with the NQTL analyses documentation. For health insurance issuers, the expenses have been associated with hiring additional staffing to support the documentation requests from group health plans, DOL, HHS, and states, as well as hiring additional clinical staff, consultants and/or law firms to support the ongoing MHPAEA NQTL analyses requirements. These are teams of individuals that have been retained to support the requests by the DOL and HHS and, based on the requests and ongoing enforcement related to the reviews by the Departments, these costs will increase and be an ongoing expense.

Second, we respectfully reiterate that application of the substantially all/predominant test to NQTLs is unworkable. This test, in certain instances, would effectively prohibit common utilization management tools – raising significant quality of care and safety concerns for patients.[1] As addressed in detail in our comment letter, Congress did not intend for MHPAEA to eliminate care management techniques. Application of this test could lead to unintended consequences detrimental to the quality and safety of patient care, such as the elimination of prior authorization and concurrent care reviews for MH/SUD services given the unworkability of the substantially all/predominant test for NQTLs. We believe this test is ill-suited for NQTLs as many medical/surgical ("M/S") and MH/SUD services are not comparable, and their unique attributes skew the outcome of this test. We are concerned that application of the substantially all/predominant test to NQTLs would lead to coverage becoming less affordable for enrollees while potentially increasing the receipt of care that is lower quality or not evidence-based.

Below, we have included an example that we briefly discussed during the July 26 meeting. This example demonstrates that utilization management would be effectively prohibited in a certain situation if the Proposed Rule is finalized without further revisions. We believe this would be a common outcome for concurrent review in the Outpatient, All Other, In-Network benefit classifications.

> In this example,[2] the following M/S "all other," in-network outpatient services are subject to concurrent review:
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> - Outpatient DME (3.02% of M/S dollars)
> - Infusion Therapy (6.94% of M/S dollars)
> - Outpatient Medical (1.69% of M/S dollars)

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[1] If utilization management is prohibited, prescribed services would be provided without a review for quality and safety, which could lead to devastating results for some patients suffering from MH/SUD disorders. *See* Warehouses of Neglect: How Taxpayers are Funding Systemic Abuse in Youth Residential Treatment Facilities at https://www.finance.senate.gov/imo/media/doc/rtf_report_warehouses_of_neglect.pdf (finding that Residential Treatment Facilities' ("RTF") providers optimize per diems by filling large facilities to capacity and maximize profit by concurrently reducing the number and quality of staff in facilities; the Committee's investigation found that children at RTFs suffer harms such as the risk of physical, sexual, and emotional abuse at the hands of staff and peers, improperly executed and overused restraint and seclusion, inadequate treatment and supervision, and non-homelike environments; and the Report recommended, among other things, prioritizing the availability and utilization of community-based services for children with behavioral health needs).

[2] Example data was obtained from an ERISA covered group health plan.

- Outpatient-Radiology (8.53% of M/S dollars)
- Outpatient-Surgical (26.41% of M/S dollars)

Together, these M/S dollar percentages total 46.59% of the M/S dollars for services in the "all other," in-network outpatient services classification subject to concurrent review. Under the substantially all/predominant test, use of concurrent review on MH/SUD services in the same benefit classification would not be allowed since use of concurrent review does not reach the two-thirds level (or 67%) on the M/S services in the same benefit classification. Thus, plans and issuers would be prohibited from applying concurrent review to any in-network MH/SUD "all other" outpatient services.

We recommend that the Administration not finalize the substantially all/predominant test. Instead, we encourage the Administration to provide clarity on the NQTL requirements as Congress effectively codified them in Consolidated Appropriations Act, 2021 ("CAA").

Third, we reiterate our recommendation that the fiduciary certification requirement should not be finalized, as it was never intended by Congress. As we noted during our meeting, employer plan sponsors already take their ERISA compliance responsibilities very seriously, and this will not change with the fiduciary certification requirement. Instead, this requirement will seriously hamper the ability of employers to design innovative and generous employee benefit plans. This requirement will obligate employers to depend upon more experts, leading to increased plan costs that could ultimately result in increased participant costs. The obligation to certify compliance will encourage employers to buy standardized benefit packages from insurers and discourage innovation and utilization of carve out vendors that offer advantageous benefits tailored to an employer's enrollee population.

Fourth, the Proposed Rule's requirements are complex; therefore, after the proposal is finalized, we welcome further sub-regulatory guidance. As a practical matter, we request that if additional sub-regulatory guidance is critical to compliance with the final rule, then it should be accounted for through a delayed enforcement date or good faith compliance standard. Additionally, if finalized as proposed, the rule alone will require regulated entities to conduct calculations and develop new structural supports that will take significant time to both set up and perform. Moreover, the final rule will be issued after plan designs have been finalized for the 2025 benefit year. Given these significant administrative challenges, we urge the Administration to delay the effective date of the final rule by at least one year – and by two years if the substantially all/predominant test is finalized. Once again, we note that a reasonable, good faith compliance standard for the first year after the effective date would better enable plans and issuers to implement the systematic changes necessary in order to comply with the Final Rule.

Finally, as we discussed during our meeting, we believe the purpose of the CAA's MHPAEA NQTL requirement is to direct the Departments of Labor, Health and Human Services, and the Treasury to issue guidance implementing and clarifying the process of identifying and documenting parity under the NQTL rule that existed at the time the CAA was enacted. On this count, the Proposed Rule fails — regulated entities have no clarity on the

number of NQTLs and the required outcomes data to document parity in operation. In addition, new ambiguities are created — for example, what is a "material" difference for the purpose of evaluating outcomes data and how are plans and issuers expected to measure meaningful benefits. Most importantly, the Proposed Rule extends the mathematical formula that applies to quantitative treatment limits to NQTLs, effectively barring many routine medical management programs. The Proposed Rule also creates a new fiduciary certification requirement that will create more risk for plan fiduciaries. None of this — extending the substantially all/predominant test to NQTLs, the fiduciary certification requirement, the requirement to provide meaningful benefits, and providing that a material difference in outcomes data is noncompliant or a presumption of noncompliance with the NQTL rule — can be found in the CAA. We request that the Administration refocus the Final Rule on what is statutorily contemplated — clarifying the pre-existing NQTL regulatory requirements that the CAA effectively codified.

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We appreciate your willingness to meet with us and consider our feedback. We look forward to continuing to offer our industry insights and working collaboratively with the Administration to improve MHPAEA compliance. Please do not hesitate to reach out to Lisa Campbell (lcampbell@groom.com) with any questions.

Sincerely,

American Benefits Council
Association for Behavioral Health and Wellness
Blue Cross Blue Shield Association
Business Group on Health
ConnectiCare
CVS Health
Elevance Health
EmblemHealth
National Coordinating Committee for Multiemployer Plans
The ERISA Industry Committee